MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

(1380 P

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Balto
City or town Bodgers Forge
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 210 Murdock Rd
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 5yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto City
City or town BALTO Co. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 210 MURDOCK RD.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Edward Amick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

B (b) Name of husband or wife Annie Louise Amick
6(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept - 3 - 1870

8. AGE:

Years	Months	Days	If less than one day
74	4	12	hrs. min.

9. Birthplace BALTO - City Md.
(Town, county, and state)
10. Usual occupation Not factory -
11. Industry or business
FATHER 12. Name John William Amick
13. Birthplace BALTO MD
MOTHER 14. Maiden name CHANEY, Amilia
15. Birthplace BALTO. Md
18. Informant Mrs. Edward Amick
Address 210 Murdock -
17. BURIED Date thereof 2-16-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory BALTO CEM
Location E. North Ave.
18. Funeral director A. Lee Oder
Address 4644 York Rd
19. 2/15 19 45 A.W. Reduck Registrar per J.M.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 12 - 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-12- 9 A.M. 1945, to 2-12-10 A.M. 1945, and that I last saw h[illegible] alive on same 19.

Immediate cause of death	DURATION
Cerebral hemmorhage	5 hr
Due to Arterio Sclerosis	yrs
Due to Senescence	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Victor Richardson M.D.
M. D. or other
Address 7301 York Rd. Date signed 2-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61381

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 11 months, 26 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 6 years, 11 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~unknown~~ 1622 W. Lanvale St.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Annie E. Anders (Hendricks)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: Theodore Anders

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): About 1871

8. AGE: Years	Months	Days	If less than one day
About 74			hrs. min.

9. Birthplace: Middlesex Co., Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER — 12. Name: Noah Jackson

13. Birthplace: Va.

MOTHER — 14. Maiden name: Annie Crittenden

15. Birthplace: Va.

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 2/22 19 45 (Date rec'd by registrar) H.C. Andrews Deputy Local Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 19 45, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 19 37, to Feb. 22 19 45 and that I last saw her alive on February 22 19 45

Immediate cause of death	DURATION
Myocardial Insufficiency	2 weeks
Due to:	
Chronic Arteriosclerotic Cardio-	Indef.
Due to: vascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner M. D. or other

Address: Catonsville-28, Md. Date signed: 2/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01382

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, institution, or street address where death occurred:
Vets.Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD #1 Box 35, Pocomoke City, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: ROBERT FRANCIS ANDERSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Quetta Anderson

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 3-19-95

8. AGE: Years	Months	Days	If less than one day
49	11	2	hrs. min.

9. Birthplace: Pocomoke City, Md.
(Town, county, and state)

10. Usual occupation: None-Disabled

11. Industry or business:

FATHER — 12. Name: Robert F. Anderson
13. Birthplace: Pocomoke, Maryland

MOTHER — 14. Maiden name: Florence L.
15. Birthplace: Pocomoke, Maryland

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery
Location: Pocomoke, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 2/23 19 45 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21, 19 45, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7, 19 45, to February 21, 19 45 and that I last saw him alive on February 21, 19 45

Immediate cause of death	DURATION
Disease of the Heart	
Coronary Arteriosclerosis	
With Myocardial Insufficiency	Unknown
Due to:	
Due to:	
Other conditions: Lobular Pneumonia; cerebral thrombosis, residuals of; cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

RMC

23. SIGNATURE: C. J. Kenney M. D. or other

Address: Fort Howard, Maryland Date signed: 2-22-45

C. J. KENNEY, M.D. CLINICAL DIRECTOR

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

01383

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Days
Hospital, institution, or street address where death occurred: Vets.Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WILLIE J. ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Nancy Anderson
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years	Months	Days	If less than one day
52			hrs. min.

9. Birthplace: Penn.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: Thomas Anderson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Morris
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. (Burial, cremation, or removal) Which? Burial
Date thereof: Feb 21-45 (month) (day) (year)
Cemetery or crematory: Baltemore National
Location: Frederick Ave
18. Funeral director: A. Lee Oder
Address: 4644 york Road
19. 2/21 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1945 at 9:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11, 1945 to February 16, 1945 and that I last saw him alive on February 16, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis, chr.	
Far Advanced, Active	8 Mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. Kenney
Geo. KENNEY, M.D. CLINICAL DIRECTOR
Address: Fort Howard, Md. Date signed: 2-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Bacon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01384

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos.

Hospital, institution, or street address where death occurred:
7708 Wilson Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7708 (14) Wilson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Winifred M. Armstrong

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Armstrong

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 2, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	7	1		

9. Birthplace: Massachusetts
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. Marie Lorden (2)
Address: 7708 Wilson Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Leonard J. Ruck

18. Funeral director: 5305 Harford Road
Address:

19. 2-3 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-3 1945 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1943 to Feb. 3 1945 and that I last saw h.. alive on Feb. 1 1945

Immediate cause of death	DURATION
Chr. myocarditis	more than
Chr. interstitial nephritis	2 yrs.
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

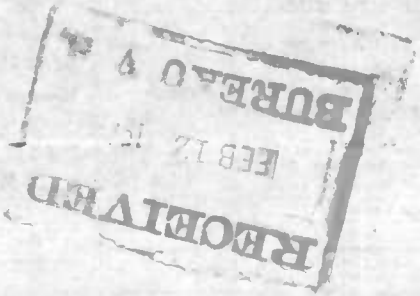
23. SIGNATURE: A. M. Bacon M.D.
M. D. or other

Address: 2810 Taylor Ave. Date signed 2-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01385

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mattie Elizabeth Ayres

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife James M. Ayres
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 11 1862

8. AGE: Years	Months	Days	If less than one day
82	6	4	..... hrs. ..... min.

9. Birthplace Rocks Harford co Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —
FATHER 12. Name John Street
13. Birthplace Rocks Md
MOTHER 14. Maiden name Elizabeth Denton
15. Birthplace Harford co Md
16. Informant John M. Bellingsley
Address Fowblesburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 18, 1945 (month) (day) (year)
Cemetery or crematory North Bend
Location Rocks Harford co Md.
18. Funeral director Martin G Kurtz
Address Jarrettsville Md.
19. 2 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1945 at 9:08 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1945, to Feb 15 1945
and that I last saw h[illegible] alive on Feb 15 1945

	DURATION
Immediate cause of death Cerebral Hemmorrhage	3 days
Due to Hypertensive Cardio-vascular Disease	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice C. Carter M.D.
Address Hampstead Md Date signed 2-15-45

M.D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2/28/45.

Subscribed and sworn before
the undersigned Notary Public
Albert E. Tucker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01386

Reg. Diat. No. 39

1. PLACE OF DEATH

County Baltimore

City or town White Hall. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town White Hall.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Mary Ayres

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Thomas J. Ayres

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 9. 1867

8. AGE: Years	Months	Days	If less than one day
77	2	13	..... hrs. ..... min.

9. Birthplace Baltimore Co. Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Josiah Carlin

13. Birthplace Baltimore Co. Md

MOTHER 14. Maiden name Charity Hannah Lytle

15. Birthplace Baltimore Co. Md

16. Informant Mrs John H. Morris

Address White Hall. Md

17. Burial Date thereof Feb. 5. 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory M.E. Kendrick

Location White Hall.

18. Funeral director Howard S. Mathias

Address White Hall. Md

19. 2/3/1945 Anna Price

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945 at 9 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Feb. 2 1945

and that I last saw h.. alive on Feb. 1 1945

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions Hy. Pertension	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Frame M. D. or other

Address Parkton, Md Date signed 2/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

01387

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

28 W. Joppa Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 W. Joppa Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rebecca Mary Bagley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Eugene Bagley

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): November 5, 1874

8. AGE: Years	Months	Days	If less than one day
70	3	3	hrs. min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Joseph Bauer

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Burgan

15. Birthplace: Maryland

16. Informant: Eugene Bagley

Address: 28 W. Joppa Road, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1945 (month) (day) (year)

Cemetery or crematory: Mays Chapel Cemetery

Location: Timonium, Balto. Co., Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. Feb. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1945, at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Feb 8 1945 and that I last saw h.er alive on Feb 8 1945

Immediate cause of death	DURATION
Coronary Occlusion	4 wks
Due to: Arterio-Sclerosis & Hypertension	Mths
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Towson, Md. Date signed: 2/9/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01388 37
Reg. Dist. No.

1. PLACE OF DEATH:
County Balto.
City or town Lutherville Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 84yrs 1mo. 3da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Katherine Barrett.

3. (b) Social Security Number

4. Sex: female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow.
6 (b) Name of husband ~~or wife~~: Thos. J. Barrett.
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 7/61
8. AGE: Years 84 | Months 1 | Days 3 | If less than one day ____hrs. ____min.
9. Birthplace: Balto Md. (Town, county, and atate)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Nicholas Jones
13. Birthplace: Md
MOTHER 14. Maiden name: Mary M Leaf.
15. Birthplace: Md.
16. Informant: Mrs Mary Shook
Address: Lutherville Md.
17. Burial (Burial, cremation, or removal—Which?) Date thereof 2/17/45 (month) (day) (year)
Cemetery or crematory: Poplar Grove
Location: Phoenix
18. Funeral director: John Burns & Son
Address: Towson, Md
19. Feb. 10 1945 (Date rec'd by registrar) Wilmer G. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1944, to Feb 10 1945;
and that I last saw her alive on Feb 8 1945.

	DURATION
Immediate cause of death: Thrombocarditis	1 yr.
Due to: Arteriosclerosis	5 yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
01 operations
01 autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer G. Ensor M. D.
M. D. or other
Address Cockeysville Md Date signed 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01389

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 513 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harriet Diana Bayne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Oliver C. Bayne

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5 1858

8. AGE: Years	Months	Days	If less than one day
86	11		..... hrs. ..... min.

9. Birthplace Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER

12. Name William Bobleter

13. Birthplace Baltimore Co, Md.

MOTHER

14. Maiden name Louise

15. Birthplace Baltimore City

16. Informant Mrs. H. D. Arrington

Address 513 Virginia Ave, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14 1945 (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Md.

18. Funeral director John Burns Sons

Address Towson, Md.

19. Feb. 12 1945 W. Carroll Hartman Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1945 at 11 45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Feb 9 1945

and that I last saw h.e.r. alive on February 9 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage.	30 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Seffman M.D

M. D. or other

Address Towson Md Date signed Feb 10 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61390

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3401 East Baltimore St.,

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JERRY BENSINK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 8-27-1879

8. AGE: Years	Months	Days	If less than one day
65	4	22	..... hrs. ..... min.

9. Birthplace: Buffalo, N.Y. (Town, county, and state)

10. Usual occupation: Tin Plate Roller

11. Industry or business:

FATHER — 12. Name: Chris Bensink

FATHER — 13. Birthplace: Holland

MOTHER — 14. Maiden name: Lola O'Connors

MOTHER — 15. Birthplace: County Cork, Ireland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24, 1945 (month) (day) (year)

Cemetery or crematory: St Mathews

Location: O'Donnell St Balto. Md.

16. Funeral director: D. Z. Carrington

Address: 21 N 25 St.

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18, 1945, at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 1945, to February 18, 1945 and that I last saw him alive on February 18, 1945

	DURATION
Immediate cause of death: Disease of Heart	
Coronary Arteriosclerosis, cardiac	15 Days
enlargement, myocardial damage,	plus
Due to: Myocardial Insufficiency	
Due to:	
Due to:	
Other conditions: Nephrosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney M. D. or other

C. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Ft. Howard, Maryland Date signed 2/ /45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30

01391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 Malbrook Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore County
(c) ~~City~~ or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Malbrook Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Leister Benson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Geo. N. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1864

8. AGE: Years 80 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Abraham Leister
13. Birthplace Md

MOTHER
14. Maiden Name Levina Haber
15. Birthplace Md

16 (a) Informant Geo. N. Benson
(b) Address 118 Malbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md. R.F.D.

18 (a) Funeral director Harry H. Mickle
(b) Address 4101 Edmondson Ave

19 (a) 2/11/45 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1945, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 9 1945
and that I last saw h as alive on Feb 9 1945

Immediate cause of death: Myocardial Disease with auricular fibrillation — Duration 1 Yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Von Schweinitz M. D.
Address 4116 Edmondson Ave Date signed 2/11/45

Verbally Local

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

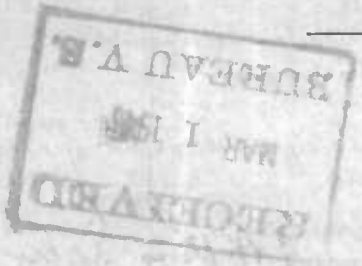
If there is more than one cause contributing to the death, the physician is expected to underline **that particular ONE** cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01392

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
A. M. Todd's Farm.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. A. M. Todd Farm.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hilda Dorotha Baylor.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Single.

6.(b) Name of husband or wife none
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 9/1944

8. AGE: Years	Months	Days	If less than one day
	8	21	hrs. min.

9. Birthplace Balto. Co.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Frank Morgan.
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Mary Baylor.
MOTHER 15. Birthplace Balto Co. Md.
16. Informant Mary Baylor.
Address Dundalk Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2 1945 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Anne Arundel County
19. Funeral director Robert L. Young
Address 804 E. Lexington St.
19. 2/2/45 19. H. McCarmon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 1 1945, at 2.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bronchopneumonia.	4-5 Dys.
Due to	
acute Coryza.	3 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. McCarmon M.D.
Deputy Medical Examiner
Address Dundalk, Md. Date signed 2/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01393

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Balto.

City or town Glyndon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Glyndon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Sarah Walters Bouldin

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Howard A. Bouldin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 23 1888

8. AGE: Years 56 | Months 6 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Henry Walters

13. Birthplace Harford Co.

MOTHER 14. Maiden name Joanna Mason

15. Birthplace St. Mary's Co.

16. Informant Howard A. Bouldin

Address Glyndon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1945 (month) (day) (year)

Cemetery or crematory St. Lukes

Location Baltimore Co.

18. Funeral director J. F. Kline & Sons

Address Reisterstown Md.

19. 2-21 1945 (d) (Local Registrar) Grace H. Arbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-45 19..... at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-45 19..... to 2-19-45 19.....

and that I last saw h.. alive on 2-18-45 19.....

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M. Suffel M. D., or other

Address Reisterstown Md. Date signed 2/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01394

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years.
Hospital, Institution, or street address where death occurred: at home
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7108 Wardman Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Belle Beebe Brister

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles W. Brister
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 30-1863

8. AGE: Years	Months	Days	If less than one day
81	1	27	....hrs. ....min.

9. Birthplace: Troy Penna
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: William Beebe
13. Birthplace: probably Rhode Island

MOTHER
14. Maiden name: Helen Shields
15. Birthplace: probably Rhode Island

16. Informant: Mrs Marjorie B. Foote (daughter)
Address: 7108 Wardman Road

17. Burial, cremation, or removal. Which?: Burial Date thereof: 2-26-45 (month) (day) (year)
Cemetery or crematory: Loudon Cemetery
Location: Baltimore-Md.

18. Funeral director: Stewart Morris Co.
Address: 1018 W. Lanvale-Balto.

19. 2/26 45 (Date rec'd by registrar) G. W. Hedgpeth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26th 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to Feb 26th 1945 and that I last saw h... alive on Feb 25 Th 1945

Immediate cause of death: Lobar Pneumonia — DURATION: 3 da.

Due to: — DURATION:

Due to: — DURATION:

Other conditions: age — DURATION:

(include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury — Injured at work?

23. SIGNATURE: C. B. Evans M.D.
M. D. or other
Address: 7201 York Rd. Date signed 2-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Acc'd. U.S.
2/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87d)

01395

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore.

City or town Owings Mills Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs 7 mos. 9 days.

Hospital, institution, or street address where death occurred:

Rosewood State Training School

How long in hospital or institution? 17 yrs 7 mos. 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 238 E. Church St

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Grace Virginia Brooker.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife unmarried

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 10. 1920.

8. AGE:

Years	Months	Days	If less than one day
24	3	5	..... hrs. ..... min.

9. Birthplace Frederick Frederick Md.

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business None.

FATHER

12. Name Edwin Jr. Brooker

13. Birthplace Frederick Maryland

MOTHER

14. Maiden name Grace Grace Grant

15. Birthplace Frederick Maryland

16. Informant Rosewood State School Rec

Address Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory St. Johns

Location Frederick Md

18. Funeral director Harry E. Early Co.

Address Frederick Md.

19. 16 Feb 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15. 1945, at 2 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1. 1938, to Feb. 15 1945 and that I last saw her alive on February 15 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 day.
Due to Bronchitis	2 days
Due to	
Other conditions Tuberous sclerosis	life
Grand Mal Epilepsy (Include pregnancy within 3 months of death)	22 yrs + (since 2 yrs old)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Isabel H. McClinton M.D.

M. D. or other

Address Rosewood Owings Mills Date signed Feb 15, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

61396

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Oella
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Oella
(If outside city or town limits, write RURAL and give nearest town)
Street No. Oella Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME David L. Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26, 1881

8. AGE: Years	Months	Days	If less than one day
63	3	1	hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Newman Brown
13. Birthplace Va.

MOTHER
14. Maiden name Sarah Jane ?
15. Birthplace Va.

16. Informant Mr. David G. Brown
Address Oella Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-45 (month) (day) (year)
Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18. Funeral director Mrs. Frances A. Hemsley
Address 578 W. Biddle St.

19. 3/1 (Date rec'd by registrar) 1945 H. Hoskins Registrar
Deputy Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1945 19 at 9 am ~~P.M.~~

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Cardiac Vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. M. Kieffer Certified Examiner M. D. or other
Address 1010 Leadenhall Date signed 2-27-45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01397

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point (19)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1007 J. Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Balto

City or town Sparrows Point, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1007 J Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Fenton Brown

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Eva

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1871

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Jeff Brown

13. Birthplace Virginia

MOTHER 14. Maiden name Myrta Jenkins

15. Birthplace Virginia

16. Informant Helen Horne

Address 1007 J. Street

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb 5/45 (month) (day) (year)

Cemetery or crematory

Location Remington, Virginia

18. Funeral director Mrs Robert A. Elliott Daughter

Address 4297 N. Caroline Street.

19. Feb 2 (Date rec'd by registrar) 1945 D. T. Harbor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to February 1 1945; and that I last saw him alive on February 1 1945.

Immediate cause of death

	DURATION
Bronchial Pneumonia	one week
Due to Myocardial Degeneration	3 mo
Due to Arteria-sclerosis	Unknown
Other conditions Chronic Arthritis	Unknown

(Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dawson La. Harbor M. D. or other

Address Harrison Point, Md. Date signed 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

01398 P

CERTIFICATE OF DEATH

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Back River Neck Road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. Back River Neck Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Olivia Brown.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Basil

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 yrs. Months Days If less than one day hrs. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Griffin

13. Birthplace Calvert County Md.

MOTHER 14. Maiden name Susan Jane ?

15. Birthplace Calvert County Md.

16. Informant Wilson Brown

Address 307 E 23rd St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25/45 (month) (day) (year)

Cemetery or crematory St Stephens Cemetery

Location East Md.

18. Funeral director Mrs. Robert A. Edwards Dgt

Address 1129 N. Caroline St.

19. 2/22 1945 A. W. Edwards 45

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945 at 11.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11 1945 to Feb 20 1945 and that I last saw h.. alive on Feb 20 1945

	DURATION
Immediate cause of death Coronary Thrombosis	5 days
Due to Arteriosclerotic Heart Dis.	about 15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John C Baier M D M. D. or other

Address 815 Eastern Ave Date signed 2/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-c)

CERTIFICATE OF DEATH

#1399 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland
How long in hospital or institution? 34 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 611 Willow Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: ROLAND ARNOLD BRYAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Bryan
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): 6-6-1889

8. AGE: Years	Months	Days	If less than one day
55	8	1	...hrs. ...min.

9. Birthplace: Dillsburg, Pa. (Town, county, and state)
10. Usual occupation: Retired Policeman
11. Industry or business

FATHER
12. Name: Charles Bryan
13. Birthplace: Mechanicsburg, Pa.

MOTHER
14. Maiden name: Catherine Arnold
15. Birthplace: Dillsburg, Pa.

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 2/10 (Date rec'd by registrar) 19 45 A. W. Kedvic M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1945 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1945 to February 8, 1945 and that I last saw him alive on February 8, 1945

Immediate cause of death	DURATION
Bronchogenic Carcinoma	
Right lung with metastases to liver	
and mediastinal lymph nodes	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations
Date of op.:
Autopsy results: Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other
Address: Fort Howard, Maryland Date signed 2-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

01400

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo.

Hospital, Institution, or street address where death occurred:

1121 Eastern Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1121 Eastern Ave Apt B.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ann Burger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Joseph M. Burger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 24 - 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Irwin Pa. (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Henry J. Detar

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden name Emily Ethery

MOTHER 15. Birthplace Pa.

18. Informant Joseph R. Burger

Address 1121 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/1/45 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Germans Hill Rd.

18. Funeral director John B Connelly

Address 418 Eastern Ave. Balto 21.

19. 3-1-45 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1945, at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Feb 26 1945

and that I last saw her alive on February 25 1945

Immediate cause of death	DURATION
Generalized Carcinomatosis	about 3 mo
Due to Adeno-carcinoma of Stomach	about 6 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Adenocarcinoma of Stomach

Dr. Finsterwald - Womens Hosp Date of op. Jan 3/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John C Baier M.D.

M. D. or other

Address 815 Eastern Ave Date signed 3-27-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EVIDENCE for change of sex shown on Film G92 3-9-45 - LL also 3-16-45 L. Plus phone call from Dr. Ensor 3-14-45 verifying sex as male. L Also Film G93 3-22-45L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

01401

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

1945 75 69

3.(a) FULL NAME: C. Andrew Burke

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M Male	W.	Married

6.(b) Name of husband or wife: Mary Elizabeth (nee Guyton)

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	4	4	hrs. min.

9. Birthplace: Balto. Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: John Conrad Burke

13. Birthplace: Germany.

MOTHER 14. Maiden name: Lynda H. Evans

15. Birthplace: Pennsylvania.

18. Informant: Mr. C. Andrew Burke

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22 1945 (month) (day) (year)

Cemetery or crematory: St. Johns Lutheran

Location: Sweet Air, Balto. Co. Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Feb. 20 19 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19 19 45 at 2:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/19 19 45 to 2/19 19 45 and that I last saw h. alive on 2/19 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs.
Due to (2nd attack)	
Due to Arterio sclerosis	
Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other

Address: Cockeysville Md. Date signed 2/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-E)

01402

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Balto.

City or town: Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Edgemere

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 25-2 Hillow Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert L. Burke

3. (b) Social Security Number: 213-16-9326

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Divorced

6.(b) Name of husband or wife: Stella Burke nee Pugh

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): 8 Oct. 17d - 1870

8. AGE: Years	Months	Days	If less than one day
74 ~~75~~			....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business:

FATHER — 12. Name: Geo. Burke

13. Birthplace: Va.

MOTHER — 14. Maiden name: Perry

15. Birthplace: Va.

16. Informant: Mrs. Helen J. Starr

Address: 934 S. Conkling St.

17. (Burial, cremation, or removal, Which?) Buried — Date thereof: 2/21/45 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave.

18. Funeral director: John B. Connelly

Address: 418 Eastern Ave. Essex 21

19. 2/20/ 19 45 (Date rec'd by registrar) — J. B. Connelly, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 d 19 45 at 1:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Fracture base of skull	Immediate
Due to: Automobile (Struck by)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident — Date of: 2/18/45

Where did injury occur? Edgemere (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public road

Means of injury: Automobile — Injured at work? No

23. SIGNATURE: M. M. Leaming M.D. Deputy medical examiner

Address: Rockdale Md. — M. D., Coroner or other

Date signed: 2/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

B 01403 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Baynesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3110 W. Garrison Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: V.

3.(a) FULL NAME Elizabeth Ann Burns.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife: Raymond R. Burns.

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1919

8. AGE: Years	Months	Days	If less than one day
25	6	7	hrs. min.

9. Birthplace: Monkton Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER 12. Name: Edward D. Howard.

FATHER 13. Birthplace: Cockeysville, Md.

MOTHER 14. Maiden name: Julia Green

MOTHER 15. Birthplace: Cockeysville, Md.

16. Informant: Raymond R. Burns.

Address: 3110 W. Garrison Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-1-45 (month) (day) (year)

Cemetery or crematory: Monkton M-E Cemetery.

Location: Monkton, Md.

18. Funeral director: Young Byers

Address: 5005 Park Heights Ave.

19. 2/28 19 45 G. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26. 45 19 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 45 19 to Feb 25 45 19 and that I last saw her alive on Feb 25 45 19

Immediate cause of death	DURATION
Brain Tumor (Glioma)	9 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Brain Tumor

Date of op. 1936.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hunt Keeler M. D. or other

Address: Towson - Md. Date signed 2/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec'd. U.S.
2/28/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

01404

1. PLACE OF DEATH

County Baltimore Md. Registration Dist. No. 4K

Village or City Edgemere No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Lucille Carr

(a) Residence: No. 2824 Lodge Farm Road St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Colored	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Willie

6. DATE OF BIRTH (month, day, and year): Feb. 12, 1915

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
30			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Domestic

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md. (State or country)

FATHER

13. NAME Edward Taylor

14. BIRTHPLACE (city or town) Va. (State or country)

MOTHER

15. MAIDEN NAME Annie Lee

16. BIRTHPLACE (city or town) Va. (State or country)

17. INFORMANT Annie Connelly (Address) 2824 Lodge Farm Road

18. BURIAL, CREMATION, OR REMOVAL Place Dellwyn Virginia Date March 1, 1945

19. UNDERTAKER Mrs. Albert A. Ellis & Daughter (Address) 1129 N. Gaeding St

20. FILED 3/1, 1945 A. W. Hedrick Registrar. P.M.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February 27 - 45 1945 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 2 - 45, 19..., to Feb 27 - 45

I last saw h... alive on Feb 27 - 45, 19...; death is said to have occurred on the date stated above, at 2:45 P.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis	unknown

Other Contributory Causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) W. H. Thomas M. D.

(Address) Owings Star Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones 3/1/45	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01405

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Transverse Ave, Victory Villa
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Neat Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Rhoda Carter nee Spargo
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): June 23 - 1866

8. AGE: Years	Months	Days	If less than one day
78	7	20	....hrs. ....min.

9. Birthplace: Fort Myers, Florida (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: George Carter
13. Birthplace: Georgia
MOTHER 14. Maiden name: Unknown
15. Birthplace: "

16. Informant: James S. Carter
Address: 24 Transverse Ave. Middle River
17. Transportation (Burial, cremation, or removal. Which?) Date thereof 2/13/46 (month) (day) (year)
Cemetery or crematory: Hollywood Cemetery
Location: Gastonia, N. Carolina
18. Funeral director: John G. Connelly
Address: 418 Eastern Ave. Essex
19. 2/13/46 (Date rec'd by registrar) Jno. G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12th 19 46, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47, to Feb 12, 19 46
and that I last saw h.. alive on Feb 12, 19 46

	DURATION
Immediate cause of death: Acute Coronary occlusion	Jan 2, 19 46
Due to: Arteriosclerosis	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Conway W. Hammond M. D. or other
Address: Essex, Md. Date signed 2/14/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01406

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Oella

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Oella

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Cecelia May Carey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John D. Carey

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 23, 1871

8. AGE:

Years	Months	Days	If less than one day
73	9	2	....hrs. ....min.

9. Birthplace: Wallafield, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Joshua M. Upton

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia Burke

15. Birthplace: Maryland

16. Informant: John D. Carey

Address: Oella, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1945 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery

Location: Ellicott City, Md.

18. Funeral director: Easton Sons

Address: Ellicott City Md.

19. 2/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25, 1945, at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940 to Feb. 25 1945 and that I last saw h.. alive on Feb 25 1945

Immediate cause of death	DURATION
Diabetes Mellitus	30 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Ellicott City Md. Date signed: 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01407

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yr.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Dundalk, R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1744 Brightview Ave.
(If rural, give LOCATION) Brookview Rd.
2.(a) If veteran, name war:

3.(a) FULL NAME Carol Joane Christy

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 12, 1944

8. AGE: Years: 1 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: George Christy
13. Birthplace: Memphis, New York

MOTHER
14. Maiden name: Anna Theresa Warren
15. Birthplace: Sparrows Point, Maryland

16. Informant: George Christy
Address: 1744 Brightview Ave. Dundalk

17. Disposal (Burial, cremation, or removal. Which?) Burial Date thereof: Feb 15 1945 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18. Funeral director: Frank H. Newell
Address: Pikesville, Maryland

19. Feb 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 19 45, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
DIARRHEA AND ENTERITIS	2 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: M. D. Davis M.D.
Asst Dept. Med. Examiner - Baltimore Co.
Address: Dundalk, Md. Date signed 2/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01408 P

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 70 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lutherville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ROBERT OTTO CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Sadie Robinson Clark

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 6-18-87

8. AGE:

Years	Months	Days	If less than one day
57	7	27	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Robert Clark
13. Birthplace: Maryland

MOTHER
14. Maiden name: Adeline Wiktkepf
15. Birthplace: Michigan

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19 1945 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Parkville, Maryland

18. Funeral director: John Burns & Son

Address: Towson, Maryland

19. 2/19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15, 1945, at 6:40P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1945, to February 15, 1945 and that I last saw him alive on February 15, 1945

Immediate cause of death	DURATION
Acute Coronary Occlusion	2 Days
Due to: Disease of the heart, Coronary Arteriosclerosis, cardiac enlargement, Myocardial damage, and Myocardial insufficiency	2 Yrs.
Other conditions: Chronic Arthritis of spine	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR (M. D. or other)

Address: Ft. Howard, Maryland Date signed: 2-16-45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (1)

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-A)

CERTIFICATE OF DEATH

01409

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Balto

County Annsslie

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Baltimore

City or town Annsslie (If outside city or town limits, write RURAL and give nearest town)

Street No. 6512 Beverly Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Mary Helen Coyle

3. (b) Social Security Number

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife John J

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 6 1897

8. AGE: Years 48 | Months 1 | Days 28 | If less than one day ____ hrs. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Matthew Kearney

13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Moran

15. Birthplace W Va

16. Informant John J Coyle

Address 6512 Beverly Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-45 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore Md

18. Funeral director George A Furley

Address Catonsville Md

19. 2/6/45 19__ (Date rec'd by registrar) [signature] Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 3rd 1945, at 2 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19__, to 19__~~ ~~and that I last saw h__ alive on 19__~~

Immediate cause of death Suicide by gas. | DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ~~Accident~~, suicide, ~~or homicide~~ Suicide Date of Feby 3rd 1945

Where did injury occur? Annslie Balt Md (City or town) (County) (State)

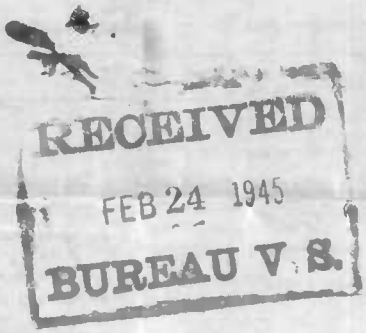
Injured at home, farm, industry, public place (where?)

Means of injury Suicide by gas Injured at work? No

23. SIGNATURE [signature] Deputy M Ex M. D. or other

Address Pikesville Md Date signed Feby 8th 1945

VS A15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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01410

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
2002 Mosby Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2002 Mosby Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Corron

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles B. Corron

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): July 22, 1881

8. AGE: Years	Months	Days	If less than one day
63	6	15	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Charles L. Smith

13. Birthplace: England

MOTHER 14. Maiden name: Miss Favill

15. Birthplace: England

16. Informant: Mr. Lee A. Basford

Address: 2002 Mosby Ave., Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1945 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Woodlawn, Md.

18. Funeral director: Phillips Funeral

Address: 4510 Liberty Heights Ave.

19. 2/9 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1945, at 8.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1945, to Feb 7 1945

and that I last saw her alive on Feb 6th 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1wk
Due to Hypertension Cardiovascular Disease	6yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos E Abbott M. D. or other

Address: 4509 Liberty Hgts Ave. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9401

CERTIFICATE OF DEATH

01411

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:
Camp Chapel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Fullerton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Camp Chapel Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARGARET A. COSTER

3. (b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Henry B. Coster

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22, 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	9	27		

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jacob J. Winkler

13. Birthplace: Balto. Co., Md.

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mr. John Coster,

Address: Camp Chapel Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22, 1945 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto., Md.

18. Funeral director: Lasahn Funeral Home

Address: 7401 Belair Road

19. 2-20-45 19 W. M. Hammond (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19th, 1945, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1st 1945 to Feb 19 1945

and that I last saw h[illegible] alive on Feb 19 at 1945

Immediate cause of death	DURATION
Coronary thrombosis	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Elliott Benson M. D. or other

Address: 1 W. Overlea Ave Date signed: 2/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44)

01412

CERTIFICATE OF DEATH

Reg. Dist. No. 4441

1. PLACE OF DEATH:

County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 7229 Holabird Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7229 Holabird Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frank George Cox

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mattie May

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 4 - 1886

8. AGE:

Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace Ludlow Pa. (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Bryan Field

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mrs Mattie Cox

Address 7229 Holabird Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Sparrows Point Rd.

18. Funeral director John H Connelly

Address 418 Eastern Ave. Essex 21 md.

19. Feb. 26 (Date rec'd by registrar) 19 45 John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 45 at 4A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 44 to Feb 23 19 45

and that I last saw him alive on Feb. 21 19 45

Immediate cause of death	DURATION
Hodgkins Disease	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David H. Andrews M.D. M. D. or other

Address 2 Kenilworth Dundalk Md Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01413

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 8 months, 16 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 11 years, 8 months, 16 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4200 Grace Comrt
(If rural, give LOCATION)

2.(a) Was veteran, name war: --

3.(a) FULL NAME: Helen Cywinski

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife: Stanley Cywinski

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1880

8. AGE: Years	Months	Days	If less than one day
64	10	20	..... hrs. ..... min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: John Kowalewski
13. Birthplace: Poland

MOTHER
14. Maiden name: Teofila Swoboda
15. Birthplace: Poland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 20 - 45 (month) (day) (year)

Cemetery or crematory: Holy Cross Cem

Location: A. A. Co.

18. Funeral director: Bernard C. Herbe

Address: 121 E West St.

19. 2/17/45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1945 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1933, to Feb. 16, 1945 and that I last saw her alive on Feb. 16, 1945

Immediate cause of death	DURATION
Myocardial failure	3 wks.
Due to: Myocarditis with fibrillation	Indef.
Due to: Hypertensive cardiovascular disease	Indef.
Other conditions: Generalized arteriosclerosis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of: .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
9/17/65

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01414

Reg. Dist. No. 42

P

1. PLACE OF DEATH:
County Balto.
City or town Md. - Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Balto
City or town HALETHROPE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5522 CARVILLE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen B. Day

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Frank W. Day

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): June 26 - 1890

8. AGE: Years: 54 | Months: 7 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Chas. Brayden

13. Birthplace: Maryland

MOTHER 14. Maiden name: Emma Dobbins

15. Birthplace: Maryland

16. Informant: Husband Frank W. Day

Address: 5622 Carville Ave.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)

Cemetery or crematory: LONDON PARK

Location: BALTO - CITY.

18. Funeral director: JOHN R KENNY

Address: 1244 LEEDSTER. HALETHROPE (27)

19. 3/2 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1945 at 7.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 20 1945 to Feby 27 1945 and that I last saw h.er alive on Feby 26 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Sudden
Due to: Lobar Pneumonia.	8 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. W Keown M D (M. D. or other)

Address: 1938 Linden Ave Date signed: 3/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Thomas
Dr. Pearson
Mad 0094
Linden & Pennsylvania St.
9-10 ——— 2-4
7-9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01415

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Balto.

City or town: Near Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Near Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William E. Dixon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22, 1853

8. AGE: Years	Months	Days	If less than one day
91	6	13	..... hrs. ..... min.

9. Birthplace: Frederick Co.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Wm. Dixon
13. Birthplace: Frederick Co.

MOTHER
14. Maiden name: Rebecca Stallions
15. Birthplace: Frederick Co.

16. Informant: Mrs. Harvey Dixon
Address: Mt. Washington

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick, Md.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. Feb. 5, 1945 (Date rec'd by registrar) Feb. 5, 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1945 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5 1936, to 2-4 1945 and that I last saw him alive on 2-2- 1945

Immediate cause of death	DURATION
Arteriosclerosis.	Since 1-16-'43
Tular Nephritis	Since 10-16-'44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. D. Eaples, M.D.
M. D. or other

Address: Reisterstown, Md. Date signed: 2-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01416 P.

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Vet. Adm. Facility, Ft. Howard, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3300 Forest Park Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROBERT L. DUDLEY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-14-91

8. AGE: Years	Months	Days	If less than one day
53	3	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Robert C. Dudley
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Bridget Caffery
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets.Adm.Fac.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/45 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Balto.

18. Funeral director: C. D. Tommy & Son
Address: 1938 E. Lafayette Ave.

19. 2/27 45 (Date rec'd by registrar) C. W. Hedrick Registrar
pencil

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb.25 1945 at 2:00p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan.30 1945 to Feb.25 1945
and that I last saw him alive on Feb.25 1945

Immediate cause of death	DURATION
Tuberculosis, Chronic, Pulmonary,	
Far Advanced	6 mos.
Due to	Plus
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR
Address: Ft Howard, Md. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.

2/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd.)

CERTIFICATE OF DEATH

01417

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years 10 mos. 18 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 7 years 10 mos 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: Light St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Minnie Duvall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 1873

8. AGE: Years	Months	Days	If less than one day
71	4	—	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business: Cotton

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Hospital Records

Address: Catonsville, 28, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Annapolis Blvd.

18. Funeral director: John F. Denny, Inc.

Address: 715 Light St.

19. 2/19/45 H. W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18, 1945, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1937, to Feb. 18, 1945 and that I last saw h... alive on Feb. 18, 1945

	DURATION
Immediate cause of death: Chronic myo-cardial failure	18 mos.
Due to: Chronic arterio-sclerotic cardiovascular disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry A. Mead M.D. M. D. or other

Address: Catonsville 28 Md Date signed: 2-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

01418

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Beechwood Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Minnie Ebershardt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Peter Ebershardt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 29 - 1864

8. AGE: Years	Months	Days	If less than one day
82	2	29	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Ebershardt
FATHER 13. Birthplace Germany
MOTHER 14. Maiden name
MOTHER 15. Birthplace Germany
16. Informant
Address N. Broadway
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 (month) 3 (day) 45 (year)
Cemetery or crematory Loudon Park
Location Baltimore, Md.
18. Funeral director J. B. Nuppnet - Son
Address 300 Eastern Place
19. 3/3 19 45 (Date rec'd by registrar) H. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27th 19 45, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 40 to Feb 27 19 45 and that I last saw h.... alive on Feb 27 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	2 weeks
Due to	
Due to	
Other conditions Chr. Nephritis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. M. Fleming M.D.
M. D. or other
Address Catonsville Md Date signed 3/3/45

Dr. Henning
205 Ingleside W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01419

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-6
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4012 Bellwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank V. Fay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma S. Crate
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19, 1878

8. AGE: Years	Months	Days	If less than one day
66	6	21	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Odd jobs
FATHER 12. Name: George W. Fay
FATHER 13. Birthplace: Balto Md.
MOTHER 14. Maiden name: Edna Cullin
MOTHER 15. Birthplace: Balto Md
16. Informant: Hospital records
Address: Catonsville, Baltimore-28, Md.
17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof (month) 2 (day) 13 (year) 45
Cemetery or ~~crematory~~: Cathedral
Location: Balto Md.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.
19. (Date rec'd by registrar) 2/12/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9, 1945, at 10:05 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1945, to February 9, 1945
and that I last saw him alive on February 9, 1945

Immediate cause of death	DURATION
Acute myocardial failure	1 hour
Due to: Chronic myocardial failure (Before 1/31/45)	
Due to:	
Other conditions: Cardiac asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed 2/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01420

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Broadway Rd., Lutherville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Broadway Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Helen O. Forwood

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George S. Forwood
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1871

8. AGE: Years	Months	Days	If less than one day
73	5	3	...hrs. ...min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wm. Waterson
13. Birthplace: England

MOTHER
14. Maiden name: Eliza Jane Mayes
15. Birthplace: Balto. Co., Md.

16. Informant: Mr. George S. Waterson
Address: Lutherville, R.F.D., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11, 1945 (month) (day) (year)
Cemetery or crematory: Carroll Chapel
Location: Lutherville R.F.D., Md.

18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. Feb. 10, 1945 (Date rec'd by registrar) Wilmer C. Ensor, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8th 1945 at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30th 1937, to February 8th 1945
and that I last saw her alive on February 8th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs.
Due to: Coronary Sclerosis	2 yrs.
Due to: Art. Sclerosis	5 yrs.
Other conditions: Hypotension (Include pregnancy within 3 months of death)	8 yrs.

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James D. Mielle Jr. M. D., or other
Address: Pikesville 8, Md. Date signed: 2/9/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-e)

CERTIFICATE OF DEATH

01421P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Veterans Administration
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2117 Sinclair Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1 ✓

3. (a) FULL NAME: Emil John FRANZ

3. (b) Social Security Number: 212-10-8346

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Charlotte M. Franz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1892

8. AGE: Years	Months	Days	If less than one day
52	1	5	..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business: Tongue, Brooks & Zimmerman

FATHER
12. Name: Louis Franz
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Augusta Frank
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records
Address: Vets. Admin. Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-45 (month) (day) (year)
Cemetery or crematory: St. Johns Luthern.
Location: Howard County

18. Funeral director: Henry Sander & Sons, Inc.
Address: North Avenue & Broadway

19. 2/7 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febuary 4 1945, at 3:00 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 1945 to Febuary 4 1945 and that I last saw him alive on Febuary 4 1945

Immediate cause of death	DURATION
Rheumatic heart disease with	
Due to mitral regurgitation and stenosis myocardial	
Due to insufficiency Class V	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR
Address: Fort Howard, Md. Date signed: Dec

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec'd. U.S.
2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01422 P

CERTIFICATE OF DEATH

Reg. Diat. No. 5 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Jan 11, 1943
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson, 4, Md.
How long in hospital or institution? Since Jan 11, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 806 N Rose St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Helen Garvey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Michael Joseph Garvey
6.(c) If alive, give age: 36 years
7. Birth date of deceased (mo., day, yr.): Feb 27, 1908

8. AGE: Years	Months	Days	If less than one day
36	11		hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Clerk + housewife
11. Industry or business:
FATHER 12. Name: Albert Jos. Koenig
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Cora Rebecca Koenig
15. Birthplace: Baltimore Md
16. Informant: Personal History, Hospital records
Address: Eudowood Sanatorium, Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: City
16. Funeral director: Ulbrich Funeral Home
Address: 2904-8 Greenmount Av
19. 2/7/45 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1945, at 5:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1943, to Feb 7 1945
and that I last saw h.. alive on February 6 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	about 2 years
Due to	
Due to	2 mos
Other conditions: Diabetes Mellitus	about 14 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William A Brides M. D. or other
Address: Towson, 4 Maryland Date signed: 2-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

01423 P.

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Baltimore

County ..... Sparrows Point Md

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... Md County .....

City or town ..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... 421 Lorraine Ave

(If rural, give LOCATION)

2.(a) If veteran, name war X

3. (a) FULL NAME John M. Gray

3. (b) Social Security Number 219-03-4699

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife ..... Ruth May Gray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 14/1892

8. AGE:

Years	Months	Days	If less than one day
52	1	27	..... hrs. ..... min.

9. Birthplace ..... Germantown Md
(Town, county, and state)

10. Usual occupation ..... Carpenter

11. Industry or business ..... Bethlehem Steel Co

FATHER
12. Name ..... Lewis S. Gray
13. Birthplace ..... London Co Va

MOTHER
14. Maiden name ..... Maria C. Gough
15. Birthplace ..... Virginia

16. Informant ..... Ruth May Gray

Address ..... 421 Lorraine Ave

17. ..... Date thereof ..... Feby 12/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Lorraine

Location ..... Dundalk Md

18. Funeral director ..... Harry A. Amuso

Address ..... 4204 Ridgewood Ave

19. 2/12 19 45 H. W. Hetrick Jr. M. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Feb. 10 19 45 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Skull	2 hrs.
Fractured left ribs.	1 "
Due to Fractured Hip Femur	1 "
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Accident Date of 2/9/45

Where did injury occur? ..... Spt. Shipyard Baltimore Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ..... Industry

Means of injury ..... Fell from Ship Injured at work? Yes

23. SIGNATURE ..... W. B. Davis M.D.
M. D. or other

Address ..... Dundalk Md Date signed 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 182

01424

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Glen Arm Md
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 416 N. Milnor St
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Estella Marie GRICE

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1902

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation

11. Industry or business Housekeeper

FATHER 12. Name Jerry Dishes

13. Birthplace Md

MOTHER 14. Maiden Name Mamie Bond

15. Birthplace Md

16 (a) Informant Mrs. Annie Gregg

(b) Address Glen Arm Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Takemade

Location Benson Md

18 (a) Funeral director Stansbeagent Bros

(b) Address Benson Md

19 (a) 2/17/45 (Date rec'd by registrar) (b) Priscilla Fouwood Registrar

MEDICAL CERTIFICATION

20. Date of death Feb 16 1945, at 1:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945, to Feb 16 1945 and that I last saw him alive on Feb 15, 1945

Immediate cause of death	Duration
Congestive Heart Failure	4 days
Due to Hypertensive Cardio-Vascular Disease	5
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Clifford F. Hudson, M.D.
M. D. or other

Address Fork Md Date signed 2/17/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01425

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or towu limits, write RURAL and give nearest town)

How long in above place of death? 19 Hrs.

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 19 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 N. Spring St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W.I ✓

3. (a) FULL NAME: WILLIAM GRINNELL

3. (b) Social Security Number: 217-03-7037

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10-20-94

8. AGE: Years	Months	Days	If less than one day
50	4		..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: James Grinnell

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lithie Bisco

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 2/26/45 (Date rec'd by registrar) A. W. Hedrick per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1945, at 7:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 1945, to February 22, 1945 and that I last saw him alive on February 22, 1945

Immediate cause of death	DURATION
Hemorrhage	Sudden
Due to: Ruptured Aorta	Unknown
Due to: Aneurysm, saccular	Unknown
Syphilitic aortitis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIR. M. D. or other A.A.P.

Address: Fort Howard, Maryland Date signed: 2-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
2/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01426

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

Masonic Home

How long in hospital or institution? 8 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6301 Bel Air Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Alice Hahn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Geo. W. Hahn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 14 - 1857

8. AGE: Years	Months	Days	If less than one day
87	4	27	..... hrs. ..... min.

9. Birthplace Carroll County Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name B. J. Matthais

13. Birthplace Carroll County, Md

MOTHER

14. Maiden name Miss Fuller

15. Birthplace Carroll County, Md.

16. Informant Laura M. Schneider

Address Masonic Home, Cockeysville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 / 14 - 45 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md

18. Funeral director Geo. L. Beyer Jr.

Address 1512 Hollins St.

19. Feb. 13 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 — 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13 1943 to Feb 10 1945

and that I last saw h.. alive on Feb. 10 1945

Immediate cause of death	DURATION
Coronary Occlusion	Immediate
Due to Coronary Sclerosis	Unknown
Due to Generalized Arteriosclerosis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Solomon Sherman M.D.

M. D. or other

Address 2424 Eutaw Place Date signed 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

CERTIFICATE OF DEATH

01427

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Brooklyneville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

H[redacted]ce of death? one years

H[redacted]r street address where death occurred:

Ho[redacted]al or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Brooklyneville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. NAME Ella F. K. Hale

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Joshua T Hall

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Sept 7-1869

8. AGE: Years: 75 | Months: 5 | Days: 12 | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER 12. Name: James Rogers

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Hall

MOTHER 15. Birthplace: Maryland

16. Informant: Mr Joshua T Hall

Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 22/45 (month) (day) (year)

Cemetery or crematory: Brooklyneville

Location: Balto Co. Md

18. Funeral director: Edward Tipton

Address: Hampstead Md

19. Feb 20 1945 (Date rec'd by registrar) C. E. Fowble M.D. Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 1945, at 6 55 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1944, to Feb. 19 1945 and that I last saw h[redacted] alive on Feb 15 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Hypertension	
Heart disease	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Fortuffid M. D. or other

Address: Hampstead Md Date signed: 2-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01428

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 weeks
Hospital, Institution, or street address where death occurred: 1876 Marshall Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nnwborn infants give residenen of mother)
State: DELAWARE County:
City or town: WILMINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 508 N. MONROE ST
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret A. Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel H. Hall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 26, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	17	hrs. min.

9. Birthplace: Wilmington Delaware (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Richard Morris
13. Birthplace: Delaware

MOTHER
14. Maiden name: MARGARET ANN MORRIS
15. Birthplace: DELAWARE

16. Informant: MRS. ELIZABETH McCRANE
Address: 1876 MARSHAL RD. DUNDALK MD

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1945 (month) (day) (year)
Cemetery or crematory: Riverview
Location: Wilmington, Delaware

18. Funeral director: Wm. J. Tickner & Sons, Inc.
Address: North & Pa. Aves. Balto, Md.

19. 2/13/45 (Date rec'd by registrar) 18. H. McCormick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16, 1945, to Feb. 13, 1945, and that I last saw h.. alive on Feb. 13, 1945.

	DURATION
Immediate cause of death: Acute Dilatation of the heart	
Due to: Rheumatic heart disease	
Due to: Rheumatic Inflammatory Disease	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underlian thn canse tn which death shnnld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eugene F. Neary M.D. M. D. of other
Address: 7001 Monument Ave. Date signed: 2-13-45
Dundalk, Md

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (932) Reg. Dist. No. 47

CERTIFICATE OF DEATH (1429)

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Kingston Park (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Kingston Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Middle River Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Frank Joseph Harrington

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Harrington

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1875

8. AGE: Years 69 | Months 2 | Days | If less than one day ____ hr. ____ min.

9. Birthplace California (Town, county, and state)

10. Usual occupation Structural Iron Worker

11. Industry or business

FATHER 12. Name John Harrington
13. Birthplace Not known

MOTHER 14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Anna Harrington
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 '45 (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cemetery
Location Balto Md

18 (a) Funeral director Frank Enoch & Son
(b) Address 909 W. Lafayette st.

19 (a) 2/24/45 (Date rec'd by registrar) (b) H. W. Kedrick per D. M. Registrar

MEDICAL CERTIFICATION

20. Date of death Feb 23 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Feb 23 1945, and that I last saw him alive on Feb 23 1945.

Immediate cause of death	Duration
Coronary Thrombosis:	Sudden
Due to Arteriosclerotic Cardiovascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo M. Baumgardner (M. D. or other)
Address Balto Md Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

01430

P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life.
Hospital, Institution, or street address where death occurred:
616 D Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Sparrows Point Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 D Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Barbara Lee Haskins.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 12/1935

8. AGE:

Years	Months	Days	If less than one day
9	5	12	..... hrs. ..... min.

9. Birthplace Sparrows Point Md.
(Town, county, and state)

10. Usual occupation none.

11. Indusfry or business

FATHER
12. Name Matthew Haskins
13. Birthplace Va.

MOTHER
14. Maiden name Olena Christian.
15. Birthplace Va.

16. Informant Matthew Haskins.
Address 616 D St. Sparrows Pt. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Feby 27/45 (month) (day) (year)
Cemetery or crematory MT Calvary
Location A.A. Co. Md.

18. Funeral director Saml W. Chase & Sons
Address 638 N. Calvert St.

19. 2/26/45 19..... A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 24 1945 at 5 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs.
Due to Rickets & Malnutrition	all life.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. McCarmine M.D.
Deputy Medical Examiner
M. D. or other
Address Hanlack Md. Date signed 2-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.
1/26/45

Evidence for change of age of deceased is shown on FILM No G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01431 44

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or towo limits, write RURAL and give nearest town)

How tong in above place of death? 23 Days

Hospital, institutioo, or street address where death occurred:

Vets. Adm. Fac., Ft. Howard, Maryland

How long io hospital or institution? 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mnther)

State: Virginia County:

City or lown: Woodstock

(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodstock, Virginia

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: WALTON HASLETT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-13-92

8. AGE: Years	Months	Days	If less than one day
52 ~~51~~	5	2	hrs. min.

9. Birthplace: Butler, Pa. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Charles Haslett

13. Birthplace: Butler, Pa.

MOTHER — 14. Maiden name: Alice Walton

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-19-45 (month) (day) (year)

Cemetery or crematory:

Location: Woodstock Va.

18. Funeral director: R. Lee Alder

Address: 4644 York Rd

19. 2/16/45 (Date rec'd by registrar) 18 G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16, 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23, 1945, to February 16, 1945

and that I last saw him alive on February 16, 1945

Immediate cause of death	DURATION
DISEASE OF THE HEART	
Coronary Arteriosclerosis, Cardiac Enlargement, mitral Insufficiency	1 Month plus
Due to: (Relative) Myocardial Damage,	
Myocardial Insufficiency	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR

M. D. or other

Address: Fort Howard, Maryland Date signed: 2-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
2/16/45

Hichew

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

P

014303

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4116 Northern Pky

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4116 Northern Pky.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irene Eudora Hichew

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife Samuel

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1860

8. AGE: Years 84 | Months 9 | Days 18 | If less than one day hrs. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name John L. Frazier

13. Birthplace ?

MOTHER 14. Maiden name Sarah Mann

15. Birthplace ?

16. Informant A Lee Hichew

Address 4116 Northern Pky

17. Burial Date thereof 2 20 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto.

Location East North Ave.

18. Funeral director Martin W. E. Dysard

Address 7110 Belair Rd.

19. 2/20 19 45 Cuthbert

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 45, at 1:P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 45, to Feb 16 19 45, and that I last saw her alive on Feb 16 19 45.

Immediate cause of death Cerebral Hemorrhage — DURATION 36hrs.

Due to Arteria - Sclerosis — 18 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph M Zierler

M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2318 Eutaw Place
Joe Seillow

45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98

CERTIFICATE OF DEATH

01433 Reg. Dist. No. 4444

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
7100 Sollers Pt Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7100 Sollers Pt. Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Florine Hildesheim

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Max C. Hildesheim
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20th 1856

8. AGE: Years	Months	Days	If less than one day
88	2	13	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: ——— Weigelt
13. Birthplace: Germany

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Herbert H. Hildesheim
Address: 7100 Sollers Pt. Rd.

17. Entombment (Burial, cremation, or removal. Which?) Date thereof 2/6/45 (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Balto. Co. Md.

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.

19. Feb. 5 1945 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2nd 1945, at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 24 1944, to Feb. 2 1945
and that I last saw h[illegible] alive on Feb. 2 1945

Immediate cause of death	DURATION
Chronic Myocarditis	3 months.
Due to	
Due to	
Other conditions Edema of lungs	24 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry B. Athey, M. D. or other
Address: 2504 N. Paca St. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01434

CERTIFICATE OF DEATH

Reg. Dist. No. 37

M

1944
1871
73

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Road
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles C. Hoffman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Emma (nee Zink)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 12, 1871

8. AGE: Years	Months	Days	If less than one day
73	11	16	..... hrs. ..... min.

9. Birthplace: Cockeysville, Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. Leulla Hattes

Address: Cockeysville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 1945 (month) (day) (year)

Cemetery or crematory: Shemwood Ep. Church

Location: Cockeysville, Md

18. Funeral director: Landon M. Brooks

Address: Sparks, Md

19. March 1 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1938 to Feb 28 1945

and that I last saw h... alive on Feb 28 1945

Immediate cause of death	DURATION
Carcinoma - (Tongue & Neck.)	3 yrs.
Due to	
Due to	
Other conditions: Osteomyelitis of right Ulna	25 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other

Address: Cockeysville Md. Date signed 3/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-D

01435

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month, 5 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 5½ Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel H. Hoffman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Burdette

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 30, 1897

8. AGE:	Years	Months	Days	If less than one day
	47	1	19	..... hrs. ..... min.

9. Birthplace: Linganore, Maryland (Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Truck driving

FATHER 12. Name: Unknown

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-45 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 3/[illegible] 19 45 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1945 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 1944, to February 18 1945 and that I last saw him alive on February 18 1945

Immediate cause of death	DURATION
Chronic parenchymatitis nephritis	21 days
Due to: General paresis, lues	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robt. E. Gardner, M.D. M. D. or other

Address: Baltimore-28, Md. Date signed 3/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

01436 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 60 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 808 N. Appleton St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME

RUSSELL WALLACE HOLLAND

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Wallace Holland

8.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): 5-22-1887

8. AGE: Years	Months	Days	If less than one day
57	9		....hrs. ....min.

9. Birthplace: Petersburg, Va.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Thomas Holland
13. Birthplace: Petersburg, Va.

MOTHER
14. Maiden name: Anna Davis
15. Birthplace: Petersburg, Va.

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Baltimore, Maryland

Location:

18. Funeral director: Wm. Cook Inc.

Address: St. Paul & Preston, Balto., Md.

19. 2/24/45 (Date received by registrar) A. Lo. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1945, at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 25, 1945, to February 23, 1945 and that I last saw him alive on February 23, 1945

Immediate cause of death	DURATION
Acute Coronary Occlusion	Immediate
Due to Disease of the Heart	2 Mos. plus
Hypertension, Coronary Arteriosclerosis	
Due to Cardiac enlargement, mitral	
Insufficiency (relative) myocardial	
Other conditions damage & Myocardial Insufficiency	
Other Cond. Nephrosclerosis, Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: local, brachial, radial and temporal arteries.

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney

C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D., or other

Address: Fort Howard, Maryland Date signed: 2-23-45

2/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01437 Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balto
City or town: Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Ebenezer Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ebenezer Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Holtzner

3. (b) Social Security Number: 214-16-8369

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Holtzner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 29th 1880

8. AGE: Years	Months	Days	If less than one day
65		21	..... hrs. ..... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Frank Holtzner
13. Birthplace

MOTHER
14. Maiden name: Mary Batchler
15. Birthplace

16. Informant: Amanda Holtzner
Address: Whitemarsh P.O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/45 (month) (day) (year)
Cemetery or crematory: Fork Methodist
Location: Balto. Co. Md

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd

19. 2/19/45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18th 1945, at 9 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1945, to Feb 18 1945
and that I last saw h.im alive on Feb 18 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R H Fuller M D (M. D. or other)
Address: Ridge Road, Balto-6 Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01438 P

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 6 mos 3 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 yrs 6 mos 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1908 Watkins Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Daniel Hoey Hoy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): July 14 1882

8. AGE:

Years	Months	Days	If less than one day
62	6	27	... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Odd jobs

11. Industry or business: None

FATHER
12. Name: Daniel Hoey Hoy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Winifred Eaton
15. Birthplace: Ireland

16. Informant: Hospital records
Address: Catonsville 28 Md

17. Burial, cremation, or removal. Which? Burial
Date thereof: Feb 13 1945 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Balto City

18. Funeral director: Robt C. Walter
Address: Paul & Stricker Sts

19. 2/12 1945 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945 at 12 15 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 7 1944 to Feb 10 1945
and that I last saw him alive on Feb 10 1945

Immediate cause of death	DURATION
Pulmonary Edema	24 hrs
Due to Chronic Myocardial failure	2 yrs
Due to Arteriosclerotic cardiovascular disease	Indef
Other conditions: Right Hemiplegia	"

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Henry A Mead M.D.
M. D. or other
Address: Catonsville 28 Md Date signed: 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01439

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-B

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Pengues
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3401 Eastern Ave Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ethel May Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	25	hrs. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual occupation Homemaker
11. Industry or business

MOTHER FATHER
12. Name Alexander Hughes
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden name Annie R. Evans
15. Birthplace Balto. Co. Md.

16. Informant Miss Nellie Evans
Address 3401 Eastern Ave Blvd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 7, 1945 (month) (day) (year)
Cemetery or crematory Bonley
Location Sparks, Md
18. Funeral director Landon M. Brooks
Address Sparks, md.
19. March 5 1945 Dawson L. Harbey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945 at 10 00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1944 to Feb 28 1945 and that I last saw h.. alive on February 26 1945

Immediate cause of death	DURATION
Coronary Occlusion.	
Due to Rheumatic Heart Disease Decompensated	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John C. Baier MD
M. D. or other
Address 815 Eastern Ave Date signed March 5 1945

Dr Baier 8/5 - Eastern

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01440

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred:
501 Dorsey ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 Dorsey ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Marie Elizabeth Hutson.

3.(b) Social Security Number NONE

4. Sex: Fem.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edwd Thomas Hutson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 25/1911
8. AGE: Years 33 | Months 4 | Days 18 | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business: at Home
FATHER 12. Name: Edwin F. Rose
FATHER 13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Anna Munder
MOTHER 15. Birthplace: Baltimore Md.
16. Informant: Edwd T. Hutson
Address 501 Dorsey Ave, Essex Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB. 10/45 (month) (day) (year)
Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.
18. Funeral director Lilly and Beiler INC.
Address 403 S. WOLFE ST.
19 2/9/ 19 45 (Date rec'd by registrar) John D Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 7 19 45 at 8 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary occlusion	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J M Carmine MD
M. D. or other
Address Cockeysville, Md. Date signed 7/7/45

Dr. T. S. Eastlund Med Arts Bldg 24 0204

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01441 38

Reg. Diat. No.

1. PLACE OF DEATH:

County: Balto

~~City or~~ town: Woodbrook

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mercy Villa Bellona Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

~~City or~~ town: Woodbrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bellona Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME: Carl Edward Johnson

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): Sept 12th 1902

8. AGE: Years	Months	Days	If less than one day
42	4	26	...hrs. ...min.

9. Birthplace: Chicago Ill (Town, county, and state)

10. Usual occupation: Treasurer

11. Industry or business: Ready Built Products Co

MOTHER FATHER

12. Name: Alfred Johnson

13. Birthplace: Sweden

14. Maiden name: Anna Johnson

15. Birthplace: Sweden

16. Informant: V. George Johnson

Address: Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)

Cemetery or ~~crematory~~: Parkwood

Location: Parkville Md.

18. Funeral director: William Cook Inc

Address: 1217 St. Paul St

19. 2/10 19 45 [signature] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8th 19 45 at 6 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 19 43 to Feb. 8 19 45 and that I last saw him alive on Feb. 5 19 45

Immediate cause of death	DURATION
Carcinoma of Liver (primary)	2 yrs. (?)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Liver

Date of op. Dec. 7, 1943

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sheldon Eastlund M. D. or other

Address: 1 W. Mt. Vernon Pl. Balto Date signed 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Gel. 2500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01442P

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore.
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Veteran Administration Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 S. Carey St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William R. Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Blanche Spees Johnson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1874

8. AGE: Years	Months	Days	If less than one day
70	9	4	hrs. min.

9. Birthplace Delaware
(Town, county, and state)
10. Usual occupation Retired Telegrapher
11. Industry or business Penn R.R.

FATHER
12. Name Richard M. Johnson
13. Birthplace Delaware

MOTHER
14. Maiden name Patience G. Tinley
15. Birthplace Delaware

16. Informant Mrs. Blanche S. Johnson
Address 18 S. Carey St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16/45 (month) (day) (year)
Cemetery or crematory Baltimore National
Location Frederick Rd. Baltimore, Md.

18. Funeral director Harry F. Little
Address 4101 E. Monument Ave

19. 2/15 45 C.W. Hedrick
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 11 1945 at about 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. McCarmack M.D.
Deputy Medical Examiner
M.D. or other
Address Date signed 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. V.S.
2/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

01443

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Chattolanee
(If ontside city or towo limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, insttitution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn infants give resideoce of mother)
State: Maryland County: Balto.
City or town: Chattolanee, Md.
(If outside city or town limits, write RURAL and give oearest town)
Street No. Chattolanee Hill
(If rural, give LOCATION)
2.(a) If veleran, name war: None

3.(a) FULL NAME: Charles Sterling Joyce, Sr.

3.(b) Social Security Number: 217-03-4779

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husbaod or wife: Sara Knapp Joyce
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct.-3-1885

8. AGE: Years	Mooths	Days	If less than one day
59	4	23	....hrs. ....min.

9. Birthplace: Bethel, Conn. (Town, coonty, and state)
10. Usual occupation: Hatter
11. Industry or business
FATHER 12. Name: Daniel B. Joyce
13. Birthplace: Norwalk, Ohio
MOTHER 14. Maiden name: Linnia Ann Hurlbett
15. Birthplace: Bethel, Conn.
16. Informant: Leroy E. Joyce
Address: 518 W. Spruce St., York, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 - 31 - 45 (month) (day) (year)
Cemetery or crematory: Danbury ~~Danbury~~ Conn. Wooster Cem. Receiving Vault.
Location: Danbery, Conn.
18. Funeral director: Frank H. Newell,
Address: Pikesville, Md.

19. 2 - 27 - 45 (Date rec'd by registrar) Dr.E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb- 27 - 1945, at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 24 - 1945, to 2 - 27 1945
and that I last saw him alive on Feb. 26, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Arterio sclerosis	-
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (Coooty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr E E Nichols M. D. or other
Address: Pikesville, Md. Date signed: Feb. 27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01444

CERTIFICATE OF DEATH

Reg. Dist. No. 4441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution or street address where death occurred: Sollers Pt. Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sollers Pt. Rd
(If rural, give LOCATION)
2.(a) If veteran, name war Dr. Richd Merritt Jr.

3. (a) FULL NAME George Justice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Don't know

8. AGE: Years: about 75 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace Don't know
(Town, county, and state)

10. Usual occupation labor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Richard Merritt
Address Sol. Pt. Rd. Dundalk Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)
Cemetery or crematory Texas Glass House
Location Lockeysville.

18. Funeral director J. Connelly
Address 41 8 Eastern Ave. Emp 21

19. 2/20/ 19 45 J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 12 1945 at 1 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Some hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. McCarmine M.D.
Deputy Medical Examiner
(M.D. or other)
Address Dundalk Md. Date signed 2/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

01445 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years, 8 months, 29 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 21 years, 8 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1204 W. Lombard St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no ✓

3.(a) FULL NAME: G. Harry Keith

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: no
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	10	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: ? Carpenter
11. Industry or business: ? B. & O. R.R. Retired

FATHER
12. Name: George Keith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Calligan
15. Birthplace: Pennsylvania

16. Informant: Hospital Records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore
18. Funeral director: Frederick & Cole
Address: 1200 W. Lombard St.

19. 2/23 (Date rec'd by registrar) 1945 H. W. Bedwell M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 19 45, at 8:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 22, to February 20 19 45 and that I last saw h... im alive on February 20 19 45

	DURATION
Immediate cause of death: Coronary Occlusion	1 day
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner M. D. or other
Address: Catonsville 28, Md. Date signed: 2/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01446 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County BALTIMORE
City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? BETHLEHEM STEEL HOSPITAL
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610 So. WASHINGTON STREET
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Steve M. KROLCZYK

3. (b) Social Security Number 215-05-9438

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

8.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 27-1903

8. AGE: Years	Months	Days	If less than one day
41			hrs. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual occupation LONGSHOREMEN
11. Industry or business JARKA CORP. of BALTO.
FATHER 12. Name JOSEPH KROLCZYK
13. Birthplace POLAND
MOTHER 14. Maiden name MARY SYNORACKA
15. Birthplace POLAND
16. Informant MRS MARY KROLCZYK
Address 610 So. WASHINGTON ST
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2-6-45 (month) (day) (year)
Cemetery or crematory ST. STANISLAUS
Location BALTIMORE, Md.
18. Funeral director George A. Weber
Address 705 So. Eaton St
19. Feb 6 1945 [illegible] Registrar
(Date rec'd by registrar)
per [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945, at 11 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Coronary Occlusion	10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other
Address Asst Dept. Med. Examiner - Balto Date signed 2/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EVIDENCE for change of sex shown on Microfilm No. G92 (2) 3/6/45 mn

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

01447

CERTIFICATE OF DEATH

Reg. Dist. No. 30

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ~~Baltimore~~ Balto. Co.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3116 Weaver Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Esther Mildred Kellam

3. (b) Social Security Number none

4. Sex FEMALE ~~Male~~
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife William Kellam
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) February 10, 1895

8. AGE:

Years	Months	Days	If less than one day
50		6	....hrs. ....min.

9. Birthplace Brooklyn, New York
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None

FATHER
12. Name Edward Simonson
13. Birthplace Long Island, New York

MOTHER
14. Maiden name Esther Lagdon
15. Birthplace United States

16. Informant Hospitalrecords, Spring Grove
Address Hospital, Caonsville 28 Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)
Cemetery or crematory A F Holly
Location Onancock Va
18. Funeral director William Cook Inc
Address 1217 St Paul St

19. 2/16 (Date rec'd by registrar) 1945 H.C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 6:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death Acute cardiac failure

Due to Cardio vascular disease

Due to sudden death

Other conditions Injury

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo M Kieffer per Esther J Ball Dep Med
M. D. or other
Address 1010 Leeds ave Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

01448

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Ruxton Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Ruxton Rd.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Ruxton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Ruxton Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charlotte Melcher Kidd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Alexander C. Kidd

6(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 15 June 1898

8. AGE:

Years	Months	Days	If less than one day
46	8		hrs. min.

9. Birthplace: Fitchburg Mass.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Frank Otis Melcher
13. Birthplace: Tamrascotta Me

MOTHER
14. Maiden name: Edna Lane Melcher
15. Birthplace: New York N.Y.

16. Informant: Alexander C. Kidd
Address: Ruxton Rd, Ruxton Md.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof 2/27/45
(month) (day) (year)

Cemetery or crematory: Loudon Park Cem

Location:

18. Funeral director: Henry W. Turnbull Son
Address: McCulloh & Presgrave

19. 2/26/45 W. Carroll Jackson
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 1945, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1944 to Feb 24 1945

and that I last saw her alive on Feb 24 1945

Immediate cause of death: Carcinoma (Breast) — DURATION: 8 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert Kelly M. D. or other

Address: Towson Md Date signed 2/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

01449

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years.

Hospital, institution, or street address where death occurred: 268 Norris Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Dundalk.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 268 Norris Lane.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Philip Kochek.

3.(b) Social Security Number 217-07-4320

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-4-93.

8. AGE: Years 52 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Grodno, Russia (Poland) (Town, county, and state)

10. Usual occupation Labor.

11. Industry or business Keeper Balto Co. Dump

FATHER 12. Name

FATHER 13. Birthplace Polish. Russia

MOTHER 14. Maiden name

MOTHER 15. Birthplace Polish Russia

16. Informant Lemuel Bleem

Address 268 Norris Lane (Step-mother)

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)

Cemetery or crematory BALTIMORE NATIONAL

Location Baltimore Md.

18. Funeral director George A. Weber

Address 705 S. Linn Street

19. 2-19-45 (Date rec'd by registrar) 19 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 9 1945 at 5.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions Discharged from Veterans Adm. Ft. Howard 12-27-44. (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. McGarvine M.D. M. D. or other

Address Dundalk, Md. Date signed 2-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec'd U.S.
2/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01450 P

Reg. Diat. No. 42

1. PLACE OF DEATH:
County: Balto.
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1714 Selma Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. Co.
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1714 Selma Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN J. KRAPF

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Separated

6.(b) Name of husband or wife: Lida Krapf
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1858

8. AGE: Years	Months	Days	If less than one day
86	3	29	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: George Krapf
13. Birthplace: Sweden

MOTHER
14. Maiden name: Elizabeth Erskine
15. Birthplace: Germany

16. Informant: Mrs. Anna L. Bell
Address: 4505 Ridge Ave., Halethorpe

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/17/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 2/16 1945 (Data rec'd by registrar) C. W. Hebrich per M D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14, 1945 at 10:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1944 to Feb 14 - 1945
and that I last saw h.. alive on Feb 13 - 1945

Immediate cause of death	DURATION
Dehydration due to inability or Refusal to take fluids	7 days
Due to Cerebral arterio sclerosis & senile dementia	2 + yrs
Due to general arterio sclerosis	1 + yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frederick W. Beetler M. D. or other
Address: Feb 15 - 1945 - Medical Officer Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Ken .d.U.S.
4/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 01451 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6820 Hendon Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME Daniel Edward Krafft | **3.(b) Social Security Number** none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary F. Krafft
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 26 1869
8. AGE: Years 75 Months 8 Days 26 If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Edward Krafft
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Mary Keough
15. Birthplace: Carroll Co Md
16. Informant: Walter Jones
Address: 6820 Hendon Mill Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn Md
18. Funeral director: Milton Earl Dove
Address: 1214 Lt Court St
19. 2/24/45 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 19 45, at ..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 19 45 to Feb 22 19 45
and that I last saw h alive on Feb 22 19 45

	DURATION
Immediate cause of death: Hemiplegia	4 days
Due to: Arteriosclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. C. Samuel M. D. or other
Address 4509 Liberty Heights Ave Date signed Feb 23

1 Tremont

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

01452 44

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 226 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 226 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1309 Drew Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3. (a) FULL NAME: JOHN ANDREW LACKEY

3. (b) Social Security Number: 220-01-0566

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Viola M. Lackey

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 9-23-89

8. AGE: Years	Months	Days	If less than one day
55	4	18	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: James Lackey

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Geisser

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Marylanx

17. Burial (Burial, cremation, or removal. Which?) SINGLE ITEM. Date thereof: Feb. 16. 1945 (month) (day) (year)

Cemetery or crematory: ~~Baltimore~~ National Cemetery

Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder

Address: 4644 York Road., Balto., Md.

19. 2/15 45 A.W. Hedrick per J.M. (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11, 19[illegible] at 11:16P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 30, 1945 to Feb. 11, 1945 and that I last saw him alive on Feb. 11, 1945

Immediate cause of death	DURATION
Uremia -- 1 Week Due to	
Chronic pyelonephritis	7 mos. plus
Due to: Diverticulum of bladder, with	
gangrenous cystitis	7 Mos.
Due to:	plus
Other conditions: Cirrhosis of liver, Latent syphilis, Broncho-Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: Chr. encrusting cystitis Diverticulum of bladder Date of op. 2-6-44

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] J. J. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other

Address: Ft. Howard, Maryland Date signed: 2-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01453

Reg. Dist. No. 31

P

1. PLACE OF DEATH:
County: Balto
City or town: Lochearn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Lochearn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3700 Sylvan Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Josephine Antoinette La Motte | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married Widowed

6.(b) Name of husband or wife: Monroe W. La Motte
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 2. 1860

8. AGE: Years	Months	Days	If less than one day
about 84	3	15	hrs. ..... min.

9. Birthplace: Erie Pa.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: John E. La Motte
Address: 3700 Sylvan Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20 1945 (month) (day) (year)
Cemetery or crematory: Manchester
Location: Manchester Md.

18. Funeral director: Jacob Winkis Sons
Address: Manchester, Md.

19. 2/19 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: Feby 17 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ..... 19..... to ..... 19.....
and ~~that I last saw h~~ ..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardio-Vascular	
Due to: Diseases	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. T. O. Myers Surgery M Ex M.D. or other
Address: Towsontown Md Date signed Feby 17 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

CERTIFICATE OF DEATH

01454 R

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town 751 Avondale Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Dundalk R.2, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 751 Avondale Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cordelia L. LeCompte

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	widow

6.(b) Name of husband or wife: Thomas LeCompte
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 20, 1884

8. AGE: Years	Months	Days	If less than one day
60	~~June~~ 20th		____ hrs. ____ min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Alfred Baer
FATHER 13. Birthplace: Penna.
MOTHER 14. Maiden name: Margaret Armstrong
MOTHER 15. Birthplace: Penna.
16. Informant: Edwina Poynter
Address: 751 Avondale Rd. Dundalk, Md.
17. Burial. Date thereof Feb 20/45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A A County Md
18. Funeral director: Mrs. Robert A. Elliott Dgt
Address: 1299 N. Caroline St.
19. 2/22 45 C. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18th 1945, at 5:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1-45 19__, to Feb 18th 1945
and that I last saw h alive on Feb 18th 1945

Immediate cause of death	DURATION
Acute nephritis	3 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J. H. Thomas M.D.
M. D. or other
Address 1077 Main St Dundalk R.2 Md Date signed 2/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01455 Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural Glen Arm

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Notch Cliff. Glen Arm

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Aurelia Leidecker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1865

8. AGE: Years	Months	Days	If less than one day
79	11	8	..... hrs. ..... min.

9. Birthplace: Rochester, N.Y. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER

12. Name: Michael

13. Birthplace: Bavaria

MOTHER

14. Maiden name: Marian Meyer

15. Birthplace: Bavaria

18. Informant: Sister M. Peter Fourier

Address: Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 26/45 (month) (day) (year)

Cemetery or crematory: Notch Cliff.

Location: Glen Arm

18. Funeral director: Geo M. Frick Son

Address: 811 N Wolfe St

19. 2/24/40 (Date rec'd by registrar) M. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 19 45, at 8.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1937 to February 1945 and that I last saw h... alive on Feb. 21 1945

Immediate cause of death	DURATION
Pneumonia (Lobar)	10 days
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Glen Arm Date signed 2/23/45

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of ~~death~~ clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01456

Reg. Dist. No. 38

1. PLACE OF DEATH: Balto

County: Roy Forge

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Near Towson (If outside city or town limits, write RURAL and give nearest town)

Street No. 520 Annesley Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Albert J. Lemkuhl

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Florence Lemkuhl

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 26 1876

8. AGE:

Years	Months	Days	If less than one day
66	4	24	..... hrs. ..... min.

9. Birthplace: Balto City (Town, county, and state)

10. Usual occupation: Jeweler

11. Industry or business:

FATHER 12. Name: Henry Lemkuhl

13. Birthplace: Germany

MOTHER 14. Maiden name: Emma Elbring

15. Birthplace: Milwaukee, Wis.

16. Informant: Mrs. B. S. Sewell

Address: 520 Annesley Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23-45 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Park

Location: Balto Co.

18. Funeral director: J. F. Eline Sons

Address: Pikesville Md

19. 2 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 20 1945; at 11-30 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

and ~~that I last saw him~~ alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. T. O. Mackenty M Ex M. D. or other

Address: Pikesville Md Date signed: Feby 20 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01457

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred: 3039 Putty Hill Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3039 Putty Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PHILIP A. LINDENMEYER

3.(b) Social Security Number: 714-03-4572

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Julia J. Lindenmeyer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 3rd, 188[illegible]

8. AGE: Years	Months	Days	If less than one day
60	1	18	hrs. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: R. Ex.

FATHER — 12. Name: Leonard Lindenmeyer

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs. P. A. Lindenmeyer

Address: 3039 Putty Hill Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 24, 1945 (month) (day) (year)

Cemetery or crematory: Western

Location: Balto., Md.

18. Funeral director: Lasanke Funeral Home

Address: 7401 Belair Road

19. 2/22 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21st, 1945, at 5:30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 1944 to Feb. 21 1945 and that I last saw h[illegible] alive on Feb. 20 1945

Immediate cause of death	DURATION
Chronic myocarditis	1 yr. +
Hypertension	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. M. Bacon M. D. or other

Address: 2810 Taylor Ave. Date signed: 2/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

01458

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town White Hall, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimo

City or town White Hall, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daniel Owen Lytle

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Ida R. Lytle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace White Hall Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thomas Lytle

13. Birthplace White Hall. Md

MOTHER 14. Maiden name Eleanor Tredway

15. Birthplace White Hall. Md

16. Informant T. Herbert Lytle

Address White Hall Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20-1945 (month) (day) (year)

Cemetery or crematory Vernon

Location White Hall, Md

18. Funeral director Howard S. Mathews

Address White Hall. Md

19. Feb 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Feb. 17 1945 and that I last saw him alive on Feb. 17 45 1945

Immediate cause of death	DURATION
Carcinoma Head & Face	3yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer Bortner M.D. M. D. or other

Address White Hall Date signed Feb 19 45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

01459 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Sparrows Point - 19 -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred: Millers Island Rd & Third St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ... County ...
City or town as in #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ...
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3.(a) FULL NAME FRED LEROY MADISON.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male.	white	married.

6.(b) Name of husband or wife Emma madison.
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Jan 23. 1882.

8. AGE: Years	Months	Days	If less than one day
63		15	... hrs. ... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual occupation Barber.
11. Industry or business Hair cutting.
FATHER 12. Name Fred madison.
13. Birthplace Coryopun. Pa.
MOTHER 14. Maiden name Johnnie moore.
15. Birthplace Pa.
16. Informant Emma madison.
Address as in #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 9th 45 (month) (day) (year)
Cemetery or crematory Lorraine Cemetery
Location ...
18. Funeral director Charles P Powell
Address 2427 Edmondson Ave
19. 2/8 45 (Date rec'd by registrar) A. W. Bedsil M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7. 19 45, at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to Feb. 7 19 45.
and that I last saw him alive on Feb. 7 19 45.

	DURATION
Immediate cause of death Myocardial failure.	1 day.
Due to associated with uraemia fever.	1 week.
Due to partial intestinal obstruction. By	
Other conditions ...	

(Include pregnancy within 3 months of death)

Major findings of operations ...
Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Louis N. Collins M. D. or other
Address Sparrows Pt. md Date signed 2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

01460

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Anneslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
717 Regester Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Anneslie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 717 Regester Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Matlat

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Minnie Ummer
6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): February 14th, 1865

8. AGE: Years	Months	Days	If less than one day
80	0	4	###### min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Foreman in Steel Mill
FATHER 12. Name: ? Matlat
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Mr. G.H.Matlat (son)
Address: 816 Ridgley Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb.22,1945 (month) (day) (year)
Cemetery or crematory: Monongahela Cemetery
Location: Wilkinsburg, Pa.
18. Funeral director: George J.Ruth, Inc.
Address: 1735 Harford Avenue, Balto: Md.
19. Feb 18 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 th 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14-45 19 to 2/18/45 19 and that I last saw h alive on 2/17/45 19

Immediate cause of death	DURATION
Myocardial Degeneration	6 mos
Due to: Chronic Pyelonephritis	
Nephritis	14 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. H Herman M. D. or other
Address: 1710 E. 33rd St. Date signed: 2/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 01461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland County
(b) Street address 2812 Oakcrest Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Oakcrest Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. McCaddin

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced.~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Oct 2nd 1860

8. AGE: Years	Months	Days	If less than one day
84	4	23	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John F. McCaddin

13. Birthplace Md.

MOTHER 14. Maiden Name Isabella A. Magnus

15. Birthplace [illegible] Md.

16 (a) Informant August F. McCaddin

(b) Address 3052 Glendale Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/28/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Greenmount

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) FEB 27 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25th 1945, at 10 P. M

21. I certify that death occurred on the date above atated; that I attended deceased from Dec 11 1942 to Feb. 25 1945, and that I last saw her alive on Feb 25 1945.

Immediate cause of death Carcinoma of Liver
Toxic Jaundice

Due to

Due to

Other Conditions Chronic myocarditis
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. V. Harlold M.D.

Address 4706 Harford Road M. D. Date signed 2/26/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01462

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH

County: Baltimore

City or town: Reisterstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Reisterstown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William R. Mercer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant.

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 22, 1945

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 25 min.

9. Birthplace: Reisterstown Balto Co., Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Chas Marlett Mercer.

FATHER — 13. Birthplace: Blueymont Va.

MOTHER — 14. Maiden name: Beatrice Evelyn Feldman

MOTHER — 15. Birthplace: Hampstead Md

16. Informant: Mrs. Beatrice Mercer

Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 23/45 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: " Md

18. Funeral director: Edw. E. Tipton

Address: Hampstead Md

19. Feb 23 1945 (Date rec'd by registrar) Mina Fox Carbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1945, to Feb 22 1945

and that I last saw h— alive on Feb 22 1945

Immediate cause of death	DURATION
Prematurity —	
Due to Spontaneous Ruptured membranes.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jacob E. Bucklad M. D. or other

Address: Hampstead Md Date signed 2/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1945
69
76

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01463

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH: County Balto
City or town Freeland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Freeland (Rural) (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Earnest Merrican Sr
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Hilda I (nee Spicer)
6.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Jan. 27, 1876
8. AGE: Years 69 Months 1 Days 1 If less than one day ... hrs. ... min.
9. Birthplace Freeland, Balto. Co., Md (Town, county, and state)
10. Usual occupation Painter
11. Industry or business
FATHER 12. Name Peter Merrican
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Margaret Gemmill
15. Birthplace Balto. Co., Md.
16. Informant Mrs. Hilda Merrican
Address Freeland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 3 1945 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location Freeland, Md.
18. Funeral director London M. Brooks
Address Sparks, Md.
19. Mar. 5, 1945 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 28 1945, at 10-15 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h ... alive on ... 19~~

Immediate cause of death Cardio-Renal — DURATION
Due to Disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. T. Myer Deputy M. Ex. M. D. or other
Address Parkton, Md Date signed 9 Mar 28-1945

B. S. Snook
520 Summer Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45R)

CERTIFICATE OF DEATH

01464 P

Reg. Dist. No. 4-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Oak Lee

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs. 6 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Baltimore

City or town: Oak Lee

(If outside city or town limits, write RURAL and give nearest town)

Street No. 913 Leeds Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: none.

3.(a) FULL NAME: OLIVER-MESSERSMITH.

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Louise C. Messersmith.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January-20-1875.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	0	15		

9. Birthplace: Baltimore-Md.
(Town, county, and state)

10. Usual occupation: Retired-

11. Industry or business: -Butcher.

FATHER 12. Name: Charles E. Messersmith.

FATHER 13. Birthplace: Germany.

MOTHER 14. Maiden name: Louisa C. Messersmith.

MOTHER 15. Birthplace: Baltimore-Md.

16. Informant: Mrs. Louisa C. Messersmith.

Address: 913 Leeds Ave.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Feb. 7-1945. (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery.

Location: Baltimore-Md.

18. Funeral director: Charles J. Schwab.

Address: 505 N. Monroe St.

19. 2/6/45 (Date rec'd by registrar) 19.. Alb. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4th. 1945, at 10.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1944 to February 4 1945

and that I last saw him alive on February 4, 1945

Immediate cause of death	DURATION
Carcinoma of Sigmoid	2 mos.
Diverticulitis	2 mos.
Due to	
Due to	
Other conditions: Phlebitis left leg	10 days
Emaciation	6 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: Loops of bowel forming fecal fistula

Retroperitoneal by Rhoades Stoma Date of op. 1-5-45

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Earl Pass, Md. M. D. or other

Address: 4005 Wellens Ave. Date signed 2-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75d)

CERTIFICATE OF DEATH

01465

Reg. Dist. No. 44

Refer to husband

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Ft. Howard, Md.

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn Md- R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Severn, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: Retired

3. (a) FULL NAME: AUGUST MUEHLHAUSE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband/wife: Bessie M.

6.(c) If alive, give age: 67

7. Birth date of deceased (mo., day, yr.): 11-20-76

8. AGE: Years	Months	Days	If less than one day
68	3	6	...hrs. ...min.

9. Birthplace: Eschwege, Germany
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U.S. Army

FATHER
12. Name: Wilhelm Muehlhause
13. Birthplace: Germany

MOTHER
14. Maiden name: Doretha ?
15. Birthplace: Germany

16. Informant: Vets. Adm. Facility, Ft. Howard, Md.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 7, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Md

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. March 3- 1945 (Date rec'd by registrar) Dawson T. Kerby Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27, 1945 at 10:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1945 to February 27, 1945 and that I last saw him alive on February 27, 1945

Immediate cause of death	DURATION
Heart Disease, Hypertension	Unknown
and Coronary Arteriosclerosis	
Due to: with Myocardial Insufficiency	
Due to:	
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney M. D. or other

Address: Ft. Howard, Maryland Date signed: 2-27-45

C. J. KENNEY, M.D. CLINICAL DIRECTOR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01466

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 23 Liberty Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marie E Mulvaney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Theo E Mulvaney
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec 13 - 1884

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation:
11. Industry or business: At home
FATHER — 12. Name: John Stutzman
FATHER — 13. Birthplace: Baltimore
MOTHER — 14. Maiden name: Dont Know
MOTHER — 15. Birthplace: Germany
16. Informant: Theo E Mulvaney
Address: 23 Liberty Parkway
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 6 1945 (month) (day) (year)
Cemetery or crematory: Western Run
Location: City
18. Funeral director: Keller & Funeral Home
Address: 2004 E. Orleans St
19. 2/5/45 (Date rec'd by registrar) G. Wade Lynch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 3rd 1945, at 10 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Feb 3 1945
and that I last saw h.. alive on Feb. 2 1945
Immediate cause of death: Chronic Myocarditis and Myocardial Degeneration — DURATION: 5 yrs.
Due to: Acute Cardiac Dilitation — 3 hrs.
Due to: Arteriosclerotic C.V. Disease — 5 yrs.
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M Brown M.D.
M. D. or other
Address: Dundalk Md. Date signed: 2/3/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd U.S.
Rec 2/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01467 43 P

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Emma Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 1867

8. AGE: Years 87 | Months 6 | Days 17 | If less than one day ..... hrs. ..... min.

8. Birthplace Canada (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name (Unknown) Matthews
13. Birthplace Canada

MOTHER
14. Maiden name Unknown
15. Birthplace

18. Informant Mrs Myers
Address Summit Ave Rosedale
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)
Cemetery or crematory Baltimore
Location Baltimore Md
18. Funeral director Fullum & Son
Address 1314 E Fort Ave

19. 2/15/45 (Date rec'd by registrar) A. W. Heldrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945 at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 14 1945 and that I last saw her alive on Feb 14 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Geo W Baumgardner M. D. or other
Address Balto Md Date signed 2/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec'd U.S.
2/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01468

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Balto
1106 Vernon Ave, Ridgewood
City or town Rural, Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1106 Vernon Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Julia B. Myers

3. (b) Social Security Number

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband of wife: Late Wm. Myers
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 15, 1871
8. AGE: Years 73 | Months 6 | Days 25 | If less than one day ..... hrs. ..... min.
9. Birthplace U.S. Wash. D.C.
(Town, county, and state)
10. Usual occupation: Home
11. Industry or business
FATHER 12. Name Schaenfelder
13. Birthplace —
MOTHER 14. Maiden name —
15. Birthplace —
16. Informant Mrs. Wm. G. Plate - daughter
Address 1106 Vernon Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13/45 (month) (day) (year)
Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd
18. Funeral director Harry H. Nitzke
Address 4101 Edmondson Ave
19. Feb 12 1945 (Date rec'd by registrar) E. Kauffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945 at 10-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Burns	
Body burned.	
Due to Shock.	
Due to 2/3 of body burned on	
Other conditions accident.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Feb 10, 45
Where did injury occur? Ridgewood Balto Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Bedclothes caught on fire Injured at work? No

23. SIGNATURE Geo. McKieffer Edgar Wells M. D. or other
Address 1010 Leadenhall Date signed 2-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-d)

01469 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years, 7 months, 6 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 9 years, 7 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Colgate
(If ontside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME

John Napraski NAPIERALSKI

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: no

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 3, 1897

8. AGE: Years	Months	Days	If less than one day
47	1	27	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: farming

FATHER 12. Name: ANTONI John Napraski

13. Birthplace: ?

MOTHER 14. Maiden name: Constance Napraski NEE DARDA

15. Birthplace: ?

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-6-45 (month) (day) (year)

Cemetery or crematory: Holy Cross Polish National

Location: Baltimore County Dundalk

18. Funeral director: George R. Weber

Address: 705 S. Linn st

19. 2-5-45 (Date recd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 19 45 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to Cardio Vascular disease	
Other conditions sudden death	
Injury	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. M. Kieffer Lee Fuller Evans & Kieffer M. D. or other

Address 1010 Leader ave Date signed 2-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01479

Reg. Dist. No. 44 41

1. PLACE OF DEATH:
County BALTIMORE P. Q.
City or town Dundalk, P. Q.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County BALTO.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 FAIRVIEW AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN G. NEHUS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	MARRIED

6.(b) Name of husband or wife ELIZABETH NEHUS
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) APRIL 17 1859

8. AGE: Years	Months	Days	If less than one day
85	10	1	hrs. min.

9. Birthplace BREMEN, GERMANY
(Town, county, and state)
10. Usual occupation COOPER.
11. Industry or business KIMBALL-TYLER CO.
FATHER 12. Name CASPER NEHUS
13. Birthplace GERMANY
MOTHER 14. Maiden name MARY OSTERMANN
15. Birthplace GERMANY
16. Informant ELIZABETH NEHUS (WIFE)
Address 504 FAIRVIEW AVE.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2-22-45 (month) (day) (year)
Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE. BALTO. CO. MD.
18. Funeral director Charles S. Seiler
Address 3605 FAIT AVE. BALTO. MD.
19. 2-20-45 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 18 1945 at 7:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Feb 18 1945
and that I last saw h... alive on Feb 18 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. a. Jacob M. D. or other
Address 617 North Ave Baltimore Date signed 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01471

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Baltimore
City or town Boring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Boring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William T. Nolte

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Maggie Hamble Nolte
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Jan 10 - 18[illegible]

8. AGE:

Years	Months	Days	If less than one day
77	1	10	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business

FATHER
12. Name: Henry P Nolte
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Cole
15. Birthplace: Maryland

16. Informant: Mrs Wm T Nolte
Address: Boring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 23/45 (month) (day) (year)
Cemetery or crematory: Pleasant Grove
Location: Balto Co

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Feb 21 19 45 (Date rec'd by registrar) Irma D. Arbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/20/45 19 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-40 19 to 2-20-45 19
and that I last saw h[illegible] alive on 2-20-45 19

Immediate cause of death	DURATION
Myocarditis Chronic Decompensated	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [illegible] G Saffell M. D. or other
Address Reisterstown Md Date signed 2/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52-2

CERTIFICATE OF DEATH

01472

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Balto

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 1814 Woodside ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town 1814 Woodside ave

(If outside city or town limits, write RURAL and give nearest town)

Street No. Catonsville Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine North

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife G. Edward North

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1866

8. AGE: Years	Months	Days	If less than one day
78	10		hrs. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Morgan North

13. Birthplace Canada

MOTHER 14. Maiden name Catherine O'Neill

15. Birthplace Balty Md.

16. Informant Mrs Catherine Ford

Address 1821 St Augustine ave Elk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)

Cemetery or crematory St Augustine's

Location Elkridge Md

18. Funeral director Thos J Keenan

Address Rollins & Gilmore

19. Feb 14 19 45 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1945, at 7.40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1941, to Febr 13 1945

and that I last saw h...CR...alive on February 12, 1945

Immediate cause of death Carcinoma of Bladder C

Generalized Metastases

DURATION 3 yrs

Due to

Due to

Other conditions Secondary anemia Sept 1944

(Include pregnancy within 3 months of death)

Major findings of operations Malignant Papilloma of the Bladder Date of op. 8-16-41

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Pass M.D. M. D. or other

Address 4001 Wilkens Ave Date signed 2-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

01473 31

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Daniels
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Daniels Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jean D. Oates

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Addie Lee Oates
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1878

8. AGE: Years	Months	Days	If less than one day
67	0	0	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Wesley Oates
13. Birthplace W Va

MOTHER
14. Maiden name Unknown
15. Birthplace W Va.

16. Informant Earl Oates
Address Daniels Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-1945 (month) (day) (year)
Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18. Funeral director F.C. Heigenbottom
Address Ellicott City Md

19. 2/23/ 1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945 at 4 15/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb. 23 1945 and that I last saw him alive on Feb 22 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	13 days
Due to Arterio sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed 2/23/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

01474 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville, 28

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 months 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt.

City or town Baltimore 6

(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~Zoo G~~ 7004 Belair rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Vincent O'BRIEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28, 1875

8. AGE: Years	Months	Days	If less than one day
69 69	6	13	..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Paper hanger

11. Industry or business Theatrical Business

FATHER 12. Name John O'Brien

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden name Mary Jane Stedmann

MOTHER 15. Birthplace Maryland, Baltimore

16. Informant William J. Evers (neighbor)

Address 7004 Belair Rd, Balto 6, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 13 45 (month) (day) (year)

Cemetery or crematory Holy Rood Cemetery

Location 4300 Belair Rd.

18. Funeral director Martin E. Dugdale Sr.

Address 7110 Belair Rd

19. 2 13 45 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10th 19 45 at 3:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24 19 44 to Feb. 10th 19 45

and that I last saw him alive on February 10th 19 45

Immediate cause of death	DURATION
Cardiac failure	
Due to Cardiac fibrillation	48 hrs
Due to Chronic Myocarditis	
Other conditions Hypertension, marked arteriosclerosis, senile psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner M.D. M. D. or other

Address Spring Grove St. Hosp. Date signed 2.10.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
1/13/45

Evidence for change of name of deceased is shown on FILM No. G 94 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-2)

CERTIFICATE OF DEATH

01475

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Nunnery Lane & Edmondson Ave(Opitz Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Nunnery Lane and Edmondson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rev. ~~Albert M.~~ Max Albert Opitz

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Johanna M. Opitz
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 20, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	13	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Clergyman
11. Industry or business:

FATHER
12. Name: Edward Opitz
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna -
15. Birthplace: Germany

16. Informant: Mrs. Johanna M. Opitz
Address: Nunnery Lane & Edmondson Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/6/45 (mooth) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 2/6 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3, 45 at 10:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1943 to Feb 3 1945 and that I last saw him alive on Feb 3 1945

Immediate cause of death	DURATION
Melano Sarcoma of Eye	2 years
with metastases	
Due to to Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jayne Mowre M. D. or other
Address: Catonsville Date signed 2-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01476

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Boring (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Boring - (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Janie P. Peltzer

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John H Peltzer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27 - 1879

8. AGE:

Years	Months	Days	If less than one day
65	6	28	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER 12. Name: John Osborn
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth A Kelhurst
MOTHER 15. Birthplace: Maryland

16. Informant: Harvard Peltzer
Address: Boring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28/45 (month) (day) (year)
Cemetery or crematory: Pleasant Grove
Location: Balto Co. Md

18. Funeral director: Edw C Tipton
Address: Hargstead Md

19. Feb 26 1945 (Date rec'd by registrar) Rose M Cubaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25 1945, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to Feb. 25 1945 and that I last saw h.. alive on Jan. 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to: Hypertension	
Cardio Vascular disease	15 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Portenfield M. D. or other
Address: Hampstead Md Date signed: 2-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01477

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Parkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-5- years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Parkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Plowman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife Jennie E

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 6- 1860

8. AGE: Years	Months	Days	If less than one day
84	4	21	..... hrs. ..... min.

9. Birthplace Parkton Md (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER 12. Name Wm Plowman

13. Birthplace Md

MOTHER 14. Maiden name Margaret Kelley

15. Birthplace Md

16. (Informant) R. Parke Plowman

Address Parkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 2 1945 (month) (day) (year)

Cemetery or crematory Wiseburg

Location White Hall Md

18. Funeral director Howard S Markline

Address White Hall, Md

19. Feb 28 1945 (Date rec'd by registrar) Mrs Howard S Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945, at 6 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to Feb. 27 1945

and that I last saw him alive on Feb. 27 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Generalized arteri-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (injured at work?

23. SIGNATURE R. M. Frame M. D. or other

Address Parkton, Md Date signed 3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(45-F)

01478

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Texas

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Baltimore County Home

Stay in hospital or inst. (yrs., or mos., or days) 4 yr 11 mo. 21 day

Stay in this community (yrs., or mos., or days) 4 yr. 11 mo. 21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Texas Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Walter Presto

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife ?

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ? 1869

8. AGE: Years	Months	Days	If less than one day
About 76			hrs. min.

9. Birthplace Poland

(Town, county, and state)

10. Usual occupation Iron Worker

11. Industry or business

FATHER 12. Name Edward Presto

FATHER 13. Birthplace Poland

MOTHER 14. Maiden name Katie - unknown

MOTHER 15. Birthplace Poland.

16. Informant Mrs Anna Elliott

Address 4104 Fifth Ett. Brooklyn Md.

17. Burial Date thereof Feb. 17 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore Co. Home

Location Texas. Md.

18. Funeral director Landon Brooks

Address Sparks, Md.

19. Feb 16 19 45 Wm. J. Whitcomb

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 19 45, at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 19 40, to Feb 16 19 45, and that I last saw him alive on 2/14 19 45.

Immediate cause of death	DURATION
Carcinoma of Throat.	6 mo.
Due to	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D.

M. D., or other

Address Cockeysville Md. Date signed 2/16/45

Evidence for change of age of deceased is shown on FILM No. G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01479

Reg. Diat. No. 82

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mths
Hospital, institution, or street address where death occurred:
Res. Pvt. Home
How long in hospital or institution? 3 4 mths

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pikesville Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Emma Lee Pugh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Harley H. Pugh
B.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) January 11 - 1888

8. AGE: Years	Months	Days	If less than one day
57		24	hrs. min.

9. Birthplace Bland County Va
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name J. F. De Hart
13. Birthplace Virginia

MOTHER
14. Maiden name Mc Calmon
15. Birthplace —

16. Informant Harley H. Pugh
Address Pikesville Rd. Pikesville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8-1945 (month) (day) (year)
Cemetery or crematory West View
Location Radford, Virginia
18. Funeral director Frank H. Purnell
Address Pikesville, Maryland
19. Feb. 6 - 1945 (Date rec'd by registrar) Dr. E. E. Nichols M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1945, at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, 19—, to Feb. 6 1945
and that I last saw her alive on Jan 28 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 yrs
Due to Arteriosclerosis	?
Due to Arterial Hypertension	7-8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE E. E. Nichols M.D.
M. D. or other
Address Pikesville 8 Md Date signed 2/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 6 1945
U.S.
RECEIVED
MAR 6 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

01480

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 640 Gorsuch Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: HENRY Z. RHODES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Anna Rodes

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 9-26-82

8. AGE: Years	Months	Days	If less than one day
62	4	22	....hrs. ....min.

9. Birthplace: Mt. Wolf, Pa. (Town, county, and state)

10. Usual occupation: Elevator operator

11. Industry or business:

FATHER — 12. Name: John Rodes

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Annie Craley

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. ~~Burial~~ Removal Date thereof: Feb 18, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Manchester Cemetery

Location: Manchester, Pa.

18. Funeral director: Wm. J. Tickner

Address: Balto., Maryland

19. 2/18-45 - Dawson L. Farber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18, 1945, at 3:20A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 27, 1945, to February 18, 1945

and that I last saw him alive on February 18, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage with Hemiplegia	1 Month plus
Due to: Hypertension, arterial	Unknown
Due to:	
Other conditions: Disease of the Heart	
Hypertension & coronary arteriosclerosis	
Myocardial Insufficiency, auricular fibrillation	

(Include pregnancy within 3 months of death)

Major findings of operation: ~~Cerebral Arteriosclerosis~~ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

RMO.

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Ft. Howard, Md. Date signed: 2-18-45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

01481 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Loch Raven Blvd, Towson-4, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Loch Raven Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ELIZABETH SAUSE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Sause

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 12, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	12	... hrs. ... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name Henry Peter
13. Birthplace Germany

MOTHER
14. Maiden name Dont know
15. Birthplace Germany

16. Informant Jacob Sause
Address 2400 Kentucky Ave.,

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2/26/45
(month) (day) (year)

Cemetery or crematory Oak Lawn
Location Colgate, Md.

18. Funeral director Ullrich Funeral Home
Address 2008 Orleans St.,

19. 2/26 1945 A. W. Hedrick [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945 at 4:20 P m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1945, to Feb 22 1945
and that I last saw her alive on Feb 21 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Feb 15/45
2nd Cerebral Hemorrhage —	Feb 22/45
Due to: Arterio-sclerosis & Hypertension	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? —
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work? —

23. SIGNATURE Louis J. Krumrein M. D. or other

Address 722 N. Kenwood Ave Date signed 2/23/45

Rec'd. U.S.
2/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01482

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Vet.Adm. Facility, Ft. Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Fort Howard, Md.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2006 Baker Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Abraham Jack Schaeffer

3.(b) Social Security Number: 219-07-8334

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-12-1913

8. AGE: Years	Months	Days	If less than one day
31	3	15	hrs. min.

9. Birthplace: Lynchburg, Va. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

MOTHER / FATHER
12. Name: Moses Schaeffer
13. Birthplace: Warsaw Poland
14. Maiden name: Anna Schaeffer ne Galblum
15. Birthplace: Warsaw, Poland

16. Informant: Clinical Records, Vets.Adm.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 1. 1945 (month) (day) (year)
Cemetery or crematory: Hebrew Herring Run
Location: Bowley Lane + Philia Rd.
18. Funeral director: Sol Levinson + Bros
Address: 1124-26 W. North ave
19. (Date rec'd by registrar) 3/2 19 45 C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 19 45 at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 19 45 to Feb. 27 19 45 and that I last saw him alive on February 27 19 45

Immediate cause of death	DURATION
Pulmonary Edema	2 days
Due to: Metastases, Carcinoma of Lung	unknown
Due to: Carcinoma of left Testicle	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Orchidectomy
not operated at this fac. Date of op. unknown
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

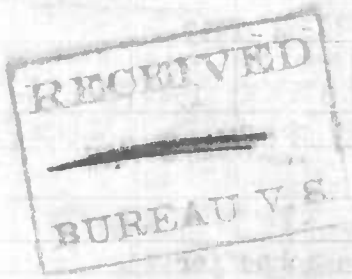
23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other
Address: Vet.Adm.Ft.Howard, Md. Date signed 2-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec'd. U.S.
2/28/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01483

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Mercy Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1624 Hollins St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME Oliver E. Leisse

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Agnes Leisse
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug 1st 1873

8. AGE: Years: 71 | Months: 6 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Westminister Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Lewis H. Leisse
13. Birthplace: Germany

MOTHER 14. Maiden name: Cornelia Bollinger
15. Birthplace: Pa

16. Informant: Henry Leisse
Address: 1624 Hollins St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md.

18. Funeral director: F. D. Wappert Inc
Address: 850 W. Baltimore St

19. 2/10 19 45 (Date rec'd by registrar) H. L. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7th 1945, at 7.0 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/6 19 45 to 2/7 19 45
and that I last saw h[illegible] alive on 2/7 19 45

Immediate cause of death	DURATION
Arterio-sclerotic	
cardio vascular disease	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Benjamin Willen M. D. or other
Address: 2032 Wilkens ave Date signed 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

01484

Reg. Dist. No. 11

1. PLACE OF DEATH:
County Balto. Co. Md.
City or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
Ebenezer Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ebenezer Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph M. Shanklin

3. (b) Social Security Number 219-03-3300

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katherine Shanklin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28th 1882

8. AGE: Years	Months	Days	If less than one day
62	3	19	hrs. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual occupation Molder
11. Industry or business G. L. Martin Co.
FATHER 12. Name Marion Shanklin
13. Birthplace Balto. Md.
MOTHER 14. Maiden name Jeanette Graver
15. Birthplace Balto. Co. Md
16. Informant Katherine Shanklin
Address Ebenezer Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)
Cemetery or crematory Waugh Chapel
Location Balto. Co.
18. Funeral director Lasahn Funeral Home
Address 7401 Belair Rd.
19. Feb 18 1945 Dr. Walter M. Hammett Baltimore, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1945 at 12:55 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 31 1943 to Feb 18 1945 and that I last saw him alive on Feb 12 1943

	DURATION
Immediate cause of death: Carcinoma of Sigmoid Colon	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: confirmatory
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harvey L. Fuller MD
M. D. or other
Address Ridge Road, Balto-6 Date signed 2/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01485 P

Reg. Dist. No. 31

1. PLACE OF DEATH:
County - Baltimore
City or town Gwynn Station Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2914 Silver Hill Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Gwynn Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2914 Silver Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CHARLES E. SHAWN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife E. Benenia Shawn
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1862

8. AGE: Years	Months	Days	If less than one day
82	7	12	hrs. min.

9. Birthplace Queen Anne Co., Md. (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name James Shawn
13. Birthplace Md.

MOTHER
14. Maiden name Mary Ann Ross
15. Birthplace Ireland

16. Informant Miss Benenia W. Shawn
Address 2914 Silver Hill Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/45 (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 2/6 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 45 at 6:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Feb 5 1945; and that I last saw him alive on Feb 4 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to Arterio Sclerosis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Warner M. D. or other
Address 2607 Garrison Blvd Date signed 2-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01486

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Garfield Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Elizabeth Shock

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Shock
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 11, 1851

8. AGE: Years	Months	Days	If less than one day
93	11	27	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Alexander Guthrie
13. Birthplace: Wilmington, Delaware
MOTHER 14. Maiden name: Eliza Engle
15. Birthplace: Wilmington, Delaware
16. Informant: Mrs. John Guthrie
Address: Monkton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14, 1945 (month) (day) (year)
Cemetery or crematory: Cremation
Location: Monkton, Md. (Rural)
18. Funeral director: Landon M. Bowles
Address: Sparks, Md.
19. 2/14/45 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1945, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 to Feb. 12 1945
and that I last saw h[illegible] alive on Feb. 10 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: Arterio-sclerosis, Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Frame M. D. or other
Address: Parkton, Md. Date signed: 2/13/45

Evidence for change of age is shown on FILM No. G 94 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01487

Reg. Diat. No. 49

1. PLACE OF DEATH:
County Baltimore
City or town Essex Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 W. Ostend St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Franklin Stanford Shue

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Ida Mae nee Dehn
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 6 - 1868

8. AGE: Years	Months	Days	If less than one day
76	7-7-	11	hrs. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mrs. Ida mae Shue
Address 106 W Ostend St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)
Cemetery or crematory Loudon Pk.
Location Frederick Rd.
18. Funeral director John D Connelly.
Address 418 Eastern Ave. Essex Md.
19. 3/2/45 (Date rec'd by registrar) John D Connelly. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28. 19 45 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M Bowers M.D.
asst Dept. Med. Exam. Baltimore Co.
Address Towsontown, Md. Date signed 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

01488

Reg. Dist. No.

1. PLACE OF DEATH:
County: Balto. Co.
City or town: Glenarm Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Glenarm Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary H. Singleton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Married

6.(b) Name of husband or wife: David Singleton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 19 - 1874

8. AGE: Years	Months	Days	If less than one day
71	-	14	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

MOTHER
12. Name: Unknown
13. Birthplace: Unknown

FATHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: David Singleton
Address: Glenarm Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4-1945 (month) (day) (year)
Cemetery or crematory: Fork M. E. Cem.
Location: Fork Md.

18. Funeral director: Clarence E. Authur
Address: Fork Md.

19. Feb. 2 1945 (Date rec'd by registrar) Clarence E. Authur Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944 to Feb 2 1945 and that I last saw h— alive on Feb 1 1945

Immediate cause of death: Congestive Heart Failure — DURATION 4 days
Due to: Hypertensive Cardio-Vascular Disease — 5 yrs
Due to:
Other conditions: Cerebral Hemorrhage with Hemiplegia L. side and body — 1 yr
(Including pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
Address: Fork Md. M. D. or other
Date signed 2/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(2 Transcripts)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01489

Reg. Dist. No. XX

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 117 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 117 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1715 Lansing Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: MATTHEW P. SINNOTT

3.(b) Social Security Number: 218-10-3784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Sinnott

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): 9-6-1900

8. AGE: Years	Months	Days	If less than one day
44	5		...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business:

FATHER — 12. Name: Lawrence Sinnott

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Gearn

MOTHER — 15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-10-45 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Herners Lane

18. Funeral director: Kendall E. Humphreys

Address: , Balto., Md.

19. 2/10 1945 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 1945, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 13, 1945, to February 7, 1945

and that I last saw him alive on February 7, 1945

	DURATION
Immediate cause of death: Disease of the Heart	
Subacute bacterial endo-carditis	4 Months
Aortic Insufficiency	
Due to: Myocardial Insufficiency	
Due to: The gunshot wounds, right lung and chest, were incurred in battle in France, 1918, World War I. C.W.S.	

Other conditions: Gunshot wounds, right lung and chest, (S. C.) The S.C. stands for service connection?

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney

C. J. KENNEY, M.D. CLINICAL DIRECTOR M.D. or other

Address: Fort Howard, Maryland Date signed: 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01490

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: ~~Towson~~ Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred: 14 Fusting Ave. None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 14 Fusting Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas P. Skelton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Catherine Doyle

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	12	....hrs. ....min.

8. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual occupation: United States Coast Guard,

11. Industry or business: Curtis Bay Station-- retired

FATHER — 12. Name: John Skelton

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Catherine ?

MOTHER — 15. Birthplace: ?

16. Informant: Mary R. Skelton

Address: 14 Fusting Ave., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/45 (month) (day) (year)

Cemetery or crematory: St. John's

Location: Long Green, Md.

18. Funeral director: John O. Mitchell & Son, Inc.

Address: 1900 Eutaw Place, Baltimore, Md.

19. 2/20 19 45 H. C. Lundgren Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

11-45

20. DATE OF DEATH: February 18 19 45 at ~~11-35~~ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
apoplexy	
Due to: Cardio vascular disease	
Other conditions: sudden death	
(Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. M. Kieffer Deceased M. D. or other Salesman

Address: 1010 Leedsdale Date signed 2-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01491

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 118 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland
How long in hospital or institution? 118 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2315 Aiken St., Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CLAUDE W. SMITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Willie M. Smith
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 7-14-90

8. AGE: Years	Months	Days	If less than one day
54	7	11	...hrs. ...min.

9. Birthplace: Ashley, Pa. (Town, county, and state)
10. Usual occupation: Policeman
11. Industry or business:
FATHER 12. Name: Jacob Smith
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Susan Orilla
15. Birthplace: Pennsylvania
16. Informant: Clinical Records, Vet. Adm. Fac. Fort Howard, Md.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28-45 (month) (day) (year)
Cemetery or crematory: Mus National Cem
Location: Frederick Md
18. Funeral director: Mr. William Valentin
Address: 2326 Aiken St. Balto. Md.
19. 2/26 1945 (Date rec'd by registrar) C. W. Hedrick per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25 1945 at 12:05A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 30 1944 to Feb. 25 1945 and that I last saw him alive on February 25 1945

Immediate cause of death	DURATION
Hypertensive Coronary Arteriosclerotic Heart Disease with Myocardial	1 yr. Plus
Due to: Damage, Cardiac Hypertrophy and Myocardial Insufficiency	
Due to:	
Other conditions: Obesity Fracture, old rt. internal malleolus & rt. fibula with nonunion of malleolus	

Major findings of operations: (Include pregnancy within 3 months of death) Amputation, lt. hand
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work? NO

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR or other
Address: Ft. Howard, Md. Date signed: 2-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

d. U. S.
Doc 2/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-E)

CERTIFICATE OF DEATH

01492

Reg. Dist. No. 4-4

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 67 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 520 North Carrollton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3. (a) FULL NAME

JAMES H. SMITH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5-27-1867

8. AGE: Years	Months	Days	If less than one day
77	8	11	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: ? Smith

13. Birthplace: ?

MOTHER — 14. Maiden name: Mary Jones

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets., Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)

Cemetery or crematory: Balto. Natl Cemetery

Location: Balto. Md.

18. Funeral director: Chas. S. Cooper

Address: 512 N. Carrollton Ave.

19. 2/12 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1945, at 7:15A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1945, to February 8, 1945 and that I last saw him alive on February 8, 1945

	DURATION
Immediate cause of death: Broncho-Pneumonia	1 Week
Due to:	
Due to:	
Other conditions: Fractured Patella	2 Months
Cerebral Arteriosclerosis, Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney M.D.

C. J. KENNEY, M.D. CLINICAL DIRECTOR M.D. or other

Address: Fort Howard, Md. Date signed: 2-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

01493

CERTIFICATE OF DEATH

Reg. Dist. No. 30

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore - Ingleside Ave

(If rural, give LOCATION)

2.(a) If veteran, name war W

3.(a) FULL NAME Nellie I Smith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Paul B

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8-1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	9	3		

9. Birthplace Mass (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Rubin Rice

13. Birthplace Mass

MOTHER 14. Maiden name Eva Shelton

15. Birthplace Mass

16. Informant Paul B Smith

Address Balt & Ingleside Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/45 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director Williams Funeral Home

Address 1397 E Lombard St

19. 2/12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945 at 4:28 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 11 1945 and that I last saw h alive on Feb 10 1945

Immediate cause of death	DURATION
Carcinoma of Bladder	6 Mo
Due to	
Due to	
Other conditions Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S Lloyd Johnson M. D., or other

Address Catonsville Date signed 2-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01494

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One day.
Hospital, institution, or street address where death occurred:
US Veterans Facility.
How long to hospital or institution? One day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 713 E 30th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: Spotts Walter J.

3.(b) Social Security Number: 218-05-2765

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: .....
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 14 1909

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
35	6	9		

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Unemployed.
11. Industry or business:
FATHER — 12. Name: Walter Spotts
13. Birthplace: Md.
MOTHER — 14. Maiden name: Grace Binder
15. Birthplace: Md.
16. Informant: Patient
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 27 1945 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore
18. Funeral director: J. Melville Jenkins
Address: 2713 Kirk Ave. Balto. Md.
19. Rec'd 1945 A. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23rd 1945, at 6 05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22nd 1945 to Feb 23 1945
and that I last saw him alive on Feb 23rd 1945

Immediate cause of death	DURATION
Hemorrhage Pulmonary	
Due to: Tuberculosis Pulmonary Chronic	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

H.Y.R.
23. SIGNATURE: G. Hemmert
M. D. or other
Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
2/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

01495 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Veterans Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 417 Tuxedo St; Balto. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI ✓

3.(a) FULL NAME: STIFFLER, Hayes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice B. Stiffler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9/25/78

8. AGE: Years	Months	Days	If less than one day
66	4	15	..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: STIFFLER, Jackson
13. Birthplace: Maryland

MOTHER
14. Maiden name: MORRIS, Mareb
15. Birthplace: Maryland

16. Informant: Record - Veterans Hospital
Address: Fort Howard Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)
Cemetery or ~~crematory~~: U.S. National
Location: Balto. Md.

18. Funeral director: William Cook
Address: Preston and St. Paul Sts.

19. 2/12 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/10 19 45 at 9.05 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/9 19 45 to 2/10 19 45
and that I last saw him alive on 2/10/ 19 45

Immediate cause of death	DURATION
Bronchogenic Carcinoma	6
of right lung	6 mo.
Due to	
Due to	
Other conditions: Cicatrix chest	
right side	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Not Performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. Kenney M. D. or other
Address. Date signed Feb 11/45

Bell

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01496

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Md.

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 632 Gorsuch Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war: Civil War ✓

3.(a) FULL NAME: HERSCHEL STRICKLER (Herschel Jerome Strickler)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed (Emma L. Strickler) 6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 3-4-[illegible]

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
96	11	18		

9. Birthplace: Buffalo, N.Y. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Daniel Strickler

13. Birthplace: New York

MOTHER — 14. Maiden name: Susan Faust

15. Birthplace: Yorktown, Pa.

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/24/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 2/24 (Date rec'd by registrar) 19 45 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 16, 1945, to Feb. 22, 1945 and that I last saw him alive on Feb. 22, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Weeks
Due to: Arteriosclerotic heart disease with myocardial damage	1 Year plus
Due to:	
Other conditions: Senility; Hemiplegia partial	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? No

23. SIGNATURE: C. J. KENNEY, M.D. CLINICIAN, D. or other

Address: FORT HOWARD, MD. Date signed: 2-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

01497 P

Reg. Dist. No. 38

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Rusleon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: at home
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Rusleon
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Overbrook Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Glen Stuart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louise B. Stuart
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 3 1887

8. AGE: Years	Months	Days	If less than one day
57	6	14	hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business: none

FATHER
12. Name: Harvey F. Stuart
13. Birthplace: Balto Md.

MOTHER
14. Maiden name: Mary W. Taylor
15. Birthplace: Annapolis Md.

16. Informant: Mrs. Louise B. Stuart (wife)
Address: Ruxton Md.

17. buried (Burial, cremation, or removal. Which?) Date thereof: Feb 19 45 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Baltimore

18. Funeral director: Stevens Mortuary Co.
Address: 108 W. Monument

19. 2/19 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 17 1945, at 2-30 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.., to ..... 19.., and ~~that I last saw h~~ alive on ..... 19..

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of: .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): .....
Means of injury: ..... Injured at work?

23. SIGNATURE: M. D. Medley M.D.
M. D. or other
Address: Pikesville Md. Date signed: Feby 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

01502

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Bloomsbury Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward William Talbott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Hallie L Talbott
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 31, 1873

8. AGE:

Years	Months	Days	If less than one day
72	0	11	..... hrs. ..... min.

9. Birthplace: Ellicott City Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: E. A. Talbott
13. Birthplace: Md.

MOTHER
14. Maiden name: Georgiana Carey
15. Birthplace: Md

16. Informant: Elenor Talbott.
Address: 218 Bloomsbury Ave. Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-45 (month) (day) (year)
Cemetery or crematory: St Johns.
Location: Ellicott City Md.
18. Funeral director: F. C. Highmanthorn
Address: Ellicott city Md
19. 2/13/45 (Date rec'd by registrar) [signature] Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945, at 7:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 1945, to Feb. 12 1945 and that I last saw him alive on Feb. 11 1945

Immediate cause of death	DURATION
Cardio-Renal Degeneration	10 yr.
Due to	
Due to	
Other conditions Senile Dementia	7 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other
Address: Catonsville, Md. Date signed 2-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01498

Reg. Dist. No. 33-

1. PLACE OF DEATH:
County Baltimore.
City or town Rural near
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs.-
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore.
City or town Rural near Parkton.-
(If outside city or town limits, write RURAL and give nearest town)
Street No. at Rayville.-
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Nelson Taylor.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife Rosa Naomi Taylor.-
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1869.-

8. AGE:

Years	Months	Days	If less than one day
75	8	11	hrs. min.

9. Birthplace Parkton, Md. R.D.
(Town, county, and state)
10. Usual occupation Trackman
11. Industry or business Railroad.

FATHER
12. Name Unknown
13. Birthplace Unknown.-

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown.-

16. Informant Mrs. Naomi Kiser
Address Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 6, 1945 (month) (day) (year)
Cemetery or crematory Pine Grove U.B. Cemetery
Location Parkton, Md. R.D.

16. Funeral director Jacob Hartenstein
Address New Freedom, Pa.

19. Feb 4- 1945 (Date rec'd by registrar) Edgar L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1945 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1942, to Feb. 3 1945
and that I last saw h... alive on Feb. 2 1945

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions Hypertension Senility (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. Frame M. D. or Other
Address Parkton, Md. Date signed 2/5/1945

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

P

01499 42

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Glen Arm (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Glen Arm, Balto. CO. Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glen Arm (If outside city or town limits, write RURAL and give nearest town)

Street No. Glen Arm. Balto. CO. Maryland (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John J. Taylor, Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Daisy E. Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 23, 1877

8. AGE: Years	Months	Days	If less than one day
67	8	29	..... hrs. ..... min.

9. Birthplace: Queen Anne Co. Maryland (Town, county, and state)

10. Usual occupation: Retired motorman, B.T.C.

11. Industry or business

FATHER 12. Name: Benjamin Franklin Taylor

13. Birthplace: Md.

MOTHER 14. Maiden name: Annie E. Skinner

15. Birthplace: MD.

16. Informant: Mr. John J. Taylor, Jr.

Address: 1633 Franklin St., NE. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Leon Baltimore

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Road

19. 2/23 (Date rec'd by Registrar) 19 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21 19 45 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1944 to Feb. 21 1945 and that I last saw him alive on Feb. 21, 1945

Immediate cause of death	DURATION
Cardiac failure	4 mo.
Due to: arteriosclerotic cardio-	
Due to: Vascular dis.	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold A. Grott, M.D. M. D. or other

Address: 6100 Harford Rd. Date signed 2/23/45

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01500

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Balto

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital~~, institution, ~~or street address where death occurred~~: Burka Convalescent Home

How long in hospital or institution? Frederick Rd (about 4 yrs)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

~~City or~~ town Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. Burka Convalescent Home (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Emma Thomas

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or ~~wife~~ Conrad Thomas

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1858

8. AGE: Years 86 Months 4 Days 29 If less than one day ....hrs. ....min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation At Home

11. Industry or business Self

FATHER

12. Name George Feller

13. Birthplace Germany

MOTHER

14. Maiden name Wilhelmina Harr

15. Birthplace Germany

16. Informant Frederick Thomas

Address 726 E. 33rd St.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 2/3/45 (month) (day) (year)

Cemetery ~~or crematory~~ Balto

Location " Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 2/2 19 45 (Date rec'd by registrar) [signature] Registrar / Deputy Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1945, at 11:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death: Acute cardiac failure

Due to: Cardio vascular disease

Due to:

Other conditions: Sudden death Inquiry (Include pregnancy within 3 months of death)

DURATION

Major findings of operations .... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide .... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. SIGNATURE [signature] Dep. Med. Exam. of Balto Co. M. D. or other

Address 1010 Reed Ave Date signed 2-1-45

(1) (T)

VS A15

*This information secured by phone from Mrs. Burka; was at the Opitz Home for 10 yrs. before entering the Burka Home. 3-9-45ams.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

01501

Reg. Diat. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Larchmont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
2305 Poplar Drive.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Larchmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2305 Poplar Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas J. Tierney

3.(b) Social Security Number: 213-03-2836

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth C. Tierney
(nee Herzberger) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 6, 1876.

8. AGE: Years	Months	Days	If less than one day
68	4	12	..... hrs. ..... min.

9. Birthplace: Ohio
(Town, county, and state)
10. Usual occupation: Monotype Operator
11. Industry or business: Baltimore Sun Paper

FATHER
12. Name: Michael Tierney
13. Birthplace: Ireland

MOTHER
14. Maiden name: Winefred Hope
15. Birthplace: Ireland

16. Informant: Mrs. Elizabeth C. Tierney
Address: 2305 Poplar Drive

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 20/45. (month) (day) (year)
Cemetery or crematory: Spring Grove Cemetery,
Location: Cin. Ohio.

18. Funeral director: Harry A. Luitzle
Address: 4101 Edmondson Ave.

19. Feb 20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18/45. 19..... at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 19 45 to Feb 18 19 45
and that I last saw h... alive on Feb. 18 19 45

Immediate cause of death	DURATION
Coronary occlusion.	½ hr.
Due to: Coronary Artery Disease	1 mo
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Herbert Goldstone M. D.
M. D. or other
Address: 2403 Linden Av Date signed: Feb. 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

015073

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Catherine Rabb Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2120 Chelsea Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ida Mae Trader

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: John W. Trader
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 28. 1894

8. AGE: Years	Months	Days	If less than one day
51	0	13	hrs. min.

6. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Frank Church
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Ida E. Leach
15. Birthplace: Md.

16. Informant: John W. Trader
Address: 2612 Talbot Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch. 13. 1945 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore, Md.

18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.

19. 2/12 1945 (Date rec'd by registrar) K. W. Kedrick Registrar pro. tem.

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Feb 10 1945
and that I last saw h.. alive on Feb 10 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to:	
Due to:	
Other conditions: advanced arteriosclerosis Hypertension (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hallie S. Pulliam M. D. or other
Address: 2220 Garrison Blvd. Date signed: Feb 11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

01504

CERTIFICATE OF DEATH

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Balto-Co., Home.
Stay in hospital or inst. (yrs., or mos., or days) 18 yr 11 mo 18 da
Stay in this community (yrs., or mos., or days) 18 yr 11 mo 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Texas Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Leonard Upshur

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 40			hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Anderson Upshur

13. Birthplace Virginia

MOTHER 14. Maiden name Eliza Alsup

15. Birthplace Virginia

16. Informant Balto. Co., Home Register

Address Texas Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 6 1945 (month) (day) (year)

Cemetery or crematory Balto. Co., Home

Location Texas Md.

18. Funeral director Landon Brooks

Address Sparks. Md.

19. Feb. 28 1945 Wm. J. Schaefer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945, at 5:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1936, to 2/28 1945

and that I last saw him alive on 2/26 1945

Immediate cause of death	Chronic Endocarditis	DURATION 16 yr.
Due to	Nephritis —	5 yrs.
Due to		
Other conditions	Both Legs amputated 1926 —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas C. Evans M. D. or other

Address Cockeysville Md Date signed 3/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

01505

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: BALTIMORE

City or town: ESSEX - STANSBURY ESTATES
(If outside city or town limits, write RURAL and give nearest town)
MIDDLE RIVER

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 1 YEAR

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MD County: BALTO.

City or town: MIDDLE RIVER
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1309 ½ 2 SCD. ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alice Christina Voorhees.

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOW

6.(b) Name of husband or wife: GEORGE B. VOORHEES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAR. 9, 189[illegible]

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	10	9		

9. Birthplace: N.J.
(Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: JOHN LANGAN
13. Birthplace: N.J.

MOTHER
14. Maiden name: FLORENCE A. ROKOSTREW
15. Birthplace: PA.

16. Informant: R.H. HUDNUT (SON IN LAW)
Address: MIDDLE RIVER MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB. 21/45 (month) (day) (year)

Cemetery or crematory: GREENWOOD

Location: TRENTON N.J.

18. Funeral director: Lilly and Zeiler INC.

Address: 403 S. WOLFE ST.

19. Feb. 18 1945 John D. Connelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 1945, at 8.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	1 HR
Due to: —	
Due to: —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: M B Davis M.D. M.D. or other

Address: First Lt. Med. Exam. - Barracks [illegible] Date signed: 2/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-E

CERTIFICATE OF DEATH

01506 33—

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore.
City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Northwest of Freeland.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rachel Ann Walker.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Daniel Walker.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 23, 1854.

8. AGE: Years	Months	Days	If less than one day
90	5	17	hrs. min.

9. Birthplace: Freeland, Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: David Williams.
13. Birthplace: Md.

MOTHER
14. Maiden name: Ann Smith.
15. Birthplace: Md.

16. Informant: Mrs. Chester Fisher
Address: Glen Rock, Pa. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: February 13 1945 (month) (day) (year)
Cemetery or crematory: St. Paul U. B. Cemetery
Location: Linebora, Balto. Co., Md.

18. Funeral director: Jacob Hartenstine
Address: New Freedom, Pa.

19. Feb. 12 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26 1943 to Feb. 9 1945 and that I last saw her alive on Feb. 8 1945

Immediate cause of death: Rheumatic Heart Disease — DURATION: 25 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis Schatanoff M.D.
M. D. or other
Address: New Freedom, Pa. Date signed: 2-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-5)

CERTIFICATE OF DEATH

011517

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Victory Villa, Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. #2 Chappell Rd. Victory Villa
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gladys A. Wallace

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Alfred R. Wallace Sr.
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Aug. 12 - 1895

8. AGE: Years	Months	Days	If less than one day
49	6		hrs. min.

9. Birthplace: Red River Co. Texas (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: A. G. Adams
13. Birthplace: Texas

MOTHER
14. Maiden name: Fannie Boyd
15. Birthplace: Texas

16. Informant: Mrs. Hazel Bradfield
Address: Victory Villa

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Feb. 12 45 (month) (day) (year)
Cemetery or crematory:
Location: Lexington, Tenn.

18. Funeral director: John G. Connelly
Address: 4.8 Eastern Ave. Edg.

19. 2/12/45 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11 d 1945, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1944 to Feb. 10 1945 and that I last saw her alive on Feb. 1, 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to: Hypertensive Cardio-vascular disease	5 yrs
Due to: Arteriolar nephrosclerosis	10 yrs
Other conditions: Hypertension, Chr.	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clarence L. Fuller MD M. D. or other
Address: Cliff Rd, Balto 6 Date signed: 2/12/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

(M)

Mr. Fuller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01508

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 26 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4005 Lawrence Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: Laura Watts

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife: Alexander Watts

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 6, 1862

8. AGE: Years	Months	Days	If less than one day
82	8	7	____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER
12. Name: Jaremiah Daettar
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Frymyer
15. Birthplace: Pennsylvania

16. Informant: Hospital records
Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17. 1945 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore Co. Md.

18. Funeral director: George W. Little,

Address: 2700 Edmondson Ave.

19. 2/15 45 (Date rec'd by registrar) G. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1943, to Feb. 13, 1945 and that I last saw her alive on Feb. 13, 1945

Immediate cause of death	DURATION
Pneumonia	2 days
Due to: Chronic myocarditis	Indef.
Due to: Arteriosclerosis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 2/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.
2/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01509

Reg. Dist. No. 49

P

1. PLACE OF DEATH: Balto Co. Sparrow Pt. Md.

County

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 612 E. 34th St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Balto-Co

State Md. County

City or town Balto Co. (If outside city or town limits, write RURAL and give nearest town)

Street No. 612 E. 34th St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marguerite H. White

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, Married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph E.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 10- 1895

8. AGE: Years: 49 Months: 4 Days: If less than one day: hrs. min.

9. Birthplace: Sparrow Pt. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Thomas G. Whalen

13. Birthplace: Ireland

MOTHER 14. Maiden name: Delia Ryan

15. Birthplace: Ireland

16. Informant: Joseph E. White

Address 75 Dundalk Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12-45 (month) (day) (year)

Cemetery or crematory Rus. Cath.

Location Old Frederick Rd.

18. Funeral director John A. Hagan

Address 3000 E. Balto St.

19. 2/10 45 (Date rec'd by registrar) A.W. Kefauver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8-45 19 45, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 42, to Feb 5 19 45

and that I last saw h alive on Feb 5 19 45-

	DURATION
Immediate cause of death: Rheumatic endocarditis (Chronic)	10 yrs.
Due to:	
Due to:	
Other conditions: Depressive psychosis	2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David H. Audeen M.D. M. D. or other

Address 2 Hurley Rd Date signed Dundalk Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01510

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred: Presbyterian Home
How long in hospital or institution? 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. Presbyterian Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara E. Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Dr. Thomas F. Williams
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1848

8. AGE:

Years	Months	Days	If less than one day
96	11	29	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
12. FATHER — Name: Arnold LaSarte
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Caroline Cook
15. MOTHER — Birthplace: Balto. Md.
16. Informant: Records Presbyterian Home
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemy.
Location: Pikesville, Md.
18. Funeral director: John O. Mitchell & Sons Inc.
Address: 1900 Eutaw St. Baltimore Md.
19. Feb 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1944, to Feb 23 1945 and that I last saw her alive on Feb 23 1945

Immediate cause of death	DURATION
Apoplexy	3 weeks
Due to: Arteriosclerosis & Hypertension	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Towson - Md. Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01511

CERTIFICATE OF DEATH

Reg. Dist. No. 41.

1. PLACE OF DEATH:
County: Balto. Dundalk
City or town: North Pt & Dobey Ave
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Dundalk Rural (North Pt. Rd.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dobey Ave, Box # 13
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella N Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed

6.(b) Name of husband or wife: James H Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9th 1902

8. AGE:

Years	Months	Days	If less than one day
43	10	19	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: " "
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: Mrs. Helen Hoke
Address: Dundalk R 2 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/2/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Balto Co.
18. Funeral director: John J. Connelly
Address: Essex Md
19. 7/19/45 19 (Date rec'd by registrar) J M Learmont Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1945 at 6 15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to: Malnutrition	
Due to: Old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J M Learmont M.D.
Address: Dundalk Md. Date signed: 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM no. G 94 APR 16 1015

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

01512

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
304 Hintons Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Hintons Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ira Augustus Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	married

6.(b) Name of husband or wife: Kettie Bell Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 6, 1886 1884

8. AGE: Years	Months	Days	If less than one day
59 60	6	18	hrs. min.

9. Birthplace: Howard County, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER — 12. Name: Wallace G. Williams
13. Birthplace: Howard County, Md.
MOTHER — 14. Maiden name: Laura V. Williams
15. Birthplace: Howard County, Md.
16. Informant: Mrs Kettie Williams (wife)
Address: 304 Hintons Lane
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-45 (month) (day) (year)
Cemetery or crematory: West Liberty
Location:
18. Funeral director: Charles L. Law
Address: 892 Madison Ave
19. 2/28 45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-27 1945 at 7.30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-20- 1945 to 2-27- 1945 and that I last saw h. alive on 2-27-45 1945

Immediate cause of death	DURATION
Acute Myocarditis	
Due to Mitral Insufficiency	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. A. Maloney M.D. (M. D. or other)
Address: Catonsville, Md. Date signed: 2/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

rec d. U.S.
1/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

01513 P

Reg. Dist. No. 46

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Sparrows Pt Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 J St
(If rural, give LOCATION)
2.(a) If veteran, name war: WW

3.(a) FULL NAME Anthony Wilson Jr.

3.(b) Social Security Number 214-22-0202

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Annie
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 5, 1868

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: South River Md. (Town, county, and state)
10. Usual occupation: Pensioner
11. Industry or business

FATHER
12. Name: Anthony Wilson
13. Birthplace: Md.

MOTHER
14. Maiden name: Tamer Johnson
15. Birthplace: Md.

16. Informant: Annie Wilson
Address: 919 J. St. Sparrows Point
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 13 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: B.A. County Md.
18. Funeral director: Mrs Robert G. Elliott & Dgt
Address: 1297 N. Caroline St.
19. 2/13/45 (Date rec'd by registrar) C.W. Hedrick per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9th 1945, at 9:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Feb 9th 1945
and that I last saw him alive on February 9th 1945

Immediate cause of death	DURATION
Chronic Valvular Heart disease	Indefinite
Due to	
Due to	
Other conditions: Arterio-sclerosis	Indefinite

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J.H. Thomas M.D.
Address: 919 J St Sparrows Pt Md (M.D., or other)
Date signed: Feb 12-45

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
2/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

01514 P

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Balto.

City or town: Woodlawn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 5537 Windsor Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Woodlawn (If outside city or town limits, write RURAL and give nearest town)

Street No.: 5537 Windsor Mill Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: A. EUGENE WOODWARD

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Flora Cushing Woodward

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5, 1870

8. AGE: Years	Months	Days	If less than one day
74	8	1	..... hrs. ..... min.

9. Birthplace: Ridley Park, Pa. (Town, county, and state)

10. Usual occupation: Retired Post Office Clerk

11. Industry or business: U. S. Gov't. - P. O. Dept.

FATHER — 12. Name: Eugene G. Woodward

FATHER — 13. Birthplace: Philadelphia, Pa.

MOTHER — 14. Maiden name: Almira Dunlop

MOTHER — 15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. Richard Brown

Address: 5537 Windsor Mill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/45 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 2/8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6, 1945, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2 1943, to 2/5 1945

and that I last saw h. he alive on 2/5 1945

Immediate cause of death	DURATION
Coronary Thrombosis c myocardial failure	1½ days
Due to: Coronary artery disease	
Due to:	
Other conditions: Angina Pectoris	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: George Lanfair M.D. M. D. or other

Address: 5106 Park Heights Ave. Date signed 2/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

01515

P

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2910 Mosher Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George A. Yienger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 23, 1892

8. AGE: Years	Months	Days	If less than one day
53		16	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Silversmith
11. Industry or business: Silver

FATHER
12. Name: John Yienger
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Frances Rosenberg
15. Birthplace: Baltimore

16. Informant: Hospital records
Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12/45 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore Md.

18. Funeral director: Robert S. Little,
Address: 2700 Edmondson Ave.

19. 2/10 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1945 at 6:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 1945 to February 8 1945 and that I last saw him alive on February 8 1945

Immediate cause of death	DURATION
Acute pulmonary edema	7 hrs.
Due to: Pulmonary thrombosis	4 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robt. E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed: 2/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01516

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred: 244 Main St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 244 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Jessie Roberts Yingling

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: Samuel S. Yingling.

6.(c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): May. 12, 1868

8. AGE: Years 76 | Months 9 | Days 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Canton, Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Caleb R. Roberts

FATHER — 13. Birthplace: Wales

MOTHER — 14. Maiden name: Caroline M. Kelly

MOTHER — 15. Birthplace: Carter, Wales

16. Informant: Judson Yingling

Address: 244 main St. Reisterstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 24, 1945 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: Um. Berryman & Sons

Address: Reisterstown, md.

19. 2-23 1945 (If rec'd by registrar) Jane Fox Auburn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-22-45 19..., at 1 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 1-1-44 19... to 2-22-45 19...

and that I last saw her alive on 2-22-45 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	1 yr.
Due to: Hypertension	
Diabetes	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury — Injured at work? —

23. SIGNATURE: Jane M. Daffin M. D. or other

Address: Reisterstown Md Date signed: 2-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

01517

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
619 Mace av

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 619 Mace ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Zavadil

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Stella Zavadil.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 27/1883
8. AGE: Years 61 Months 11 Days 20 If less than one day ... hrs. ... min.
9. Birthplace Czecho Slovakia.
(Town, county, and state)
10. Usual occupation Retired.
11. Industry or business Butcher Sk.
FATHER
12. Name Mike Zavadil.
13. Birthplace Czecho Slovakia.
MOTHER
14. Maiden name Catherine Dvorak.
15. Birthplace Czech. Slovakia.
16. Informant Mrs. Stella Zavadil.
Address 619 Mace av. Essex Md.
17. Burial Date thereof 2/9/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or ~~xxx~~ Oak Lawn
Location Baltimore, Maryland
18. Funeral director Charles E. Schimunek
Address 2601 E. Madison Street
19. 2/8 19 45 R. W. Hedrick per D. M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 6 45 at after 5 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...
Immediate cause of death Monoxide Gas poison. DURATION
Due to
Due to (Gas Hot water heater in cellar)
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Sueide Date of Feby 6/45.
Where did injury occur? Essex Balto. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home.
Means of injury Gas heater. Injured at work? no.
23. SIGNATURE ... M. D.
M. D. or other Deputy Medical Examiner
Address Dundalk. md Date signed 2/7/45

VS A15